A Synthesis of the Reflective and Scientific Counselling Psychologist Practitioner: Dynamics in Research, Practice, and Clinical Supervision

Portfolio for the Professional Doctorate in Counselling Psychology (DPsych)

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THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION REASONS:

pp 171-172:
Appendix 4. Letter authorising research.

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Section C: Case Study. The emotional effects of Anxiety: an Integrative Therapeutic approach.

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City University Declaration

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Section A: Preface

This section introduces sections B, C, and D, which all form part of this Doctoral Portfolio. An outline of each section is provided that encompasses three key roles and respective responsibilities required of a counselling psychologist within the contexts of psychotherapeutic research, practice, and clinical supervision. There are elements within the sections that at times interrelate due to contextual components of the psychotherapeutic process, although sections B, C, and D each reflect different positions required by a senior applied psychologist. These roles underpin the reflective/scientific-practitioner model, elements of which may also be attributed to the work of any psychologist/psychotherapist or counsellor.

Counselling Psychology is founded on humanistic principles (McLeod, 2003a) which in practice draws on the person-centred approach introduced by Carl Rogers (1951). This approach is where therapists rely on dialogue to help clients work through their difficulties. As Du Plock (2010) posits, humanistic practitioners seek a stance that reflects 'being with' clients in an open, creative, and inquiring way rather than 'doing to' clients as an all-knowing expert. This means successful practitioners learn from experience. "Reflection-on-action, often with colleagues, and reflection-in action, the monitoring of practice in process, are central to this learning and keep practitioners alive in the uniqueness and uncertainty of practice situations" (Strawbridge & Woolfe, 2010, pp.6-7).

Reflection also involves supervision and professional development and draws upon a self-critical stance and openness to experience (Strawbridge & Woolfe, 2003). In research, the humanistic paradigm does not employ a single theoretical focus but rather a loosely connected network of ideas (McLeod, 2003a). "The scientist-practitioner model for counselling psychology suggests that in all areas of professional activity, be it learning, practice, or research, thinking scientifically is paramount" (Blair, 2010, p.22).

The scientist-practitioner model emphasises the need to recognise and make sense of professional beliefs, actions, and communications with others; as applied psychologists, our role is to act upon everyday assumptions because applied psychology exists to act on the world (Lane & Corrie, 2006). This suggests a professional identity that develops on the interplay between practice and research, and the need for reflection and

hypotheses-testing, which allows for client-change and reformulation of ideas in the face of the evidence (Blair, 2010). This position reflects one that is perpetually open to new ideas in the aim of enhancing practice through the process of research, whether founded on empirical evidence, theory and concepts, or one in which Kasket (2012) describes as the researcher having a 'pluralistic attitude'. From this standpoint, Kasket (2012) suggests the counselling psychologist researcher draws upon divergent research methodologies to explore research questions. This means the process of research and practice is approached in a way that opens up the process towards gaining new knowledge creatively because as McLeod (2003b) proposes, the driving force of research is about something that is known but is not enough.

Section B is the main part of the portfolio and presentation of the research study. The research explores the Therapeutic Alliance (TA) as the best predictor of therapeutic outcome. The development of this study was inspired through experiences in the researcher's interpersonal therapeutic encounters with clients and because as a counselling psychologist, the therapeutic relationship (which the TA forms a part of) is core to the discipline of counselling psychology. As a counselling psychologist researcher and member of the British Psychological Society (BPS), in support of new knowledge on practice (BPS, 2009), the researcher became enthralled in the complexities involved in the TA, despite the enormous attention given in literature.

In the first part of the study, factors considered to be involved in developing and maintaining the TA are explored through qualitative research methods. The data are obtained from the multi-perspectives of qualified practising therapists where they reflect on their experiences with clients past and present.

The second object of inquiry was to investigate how therapists believe the TA is measured. Items were generated through qualitative analysis and subsequent construction of a new TA measure in the form of a survey scale. A quantitative methodology was employed to identify latent factors attributed to the TA, performed through exploratory factor analysis. The study surveyed both therapists' and trainees' views as to what extent they agreed with the measure factors, and whether factors included in the new measurement scale could heighten therapists' awareness in training, practice, and clinical supervision.

The research draws upon current evidence on the TA and TA factor models believed to be involved in therapeutic interactions between clients and therapists. This includes a popular definition of the 'working alliance' TA model, described by Bordin (1979) as a 'mutual construct' between client and therapist and conceptualised as shared goals, tasks, and an attachment bond. While accounting for Bordin's concept, this study aims to strive beyond this model to gain more understanding on the TA phenomenon.

Evidence was examined through the subjective accounts of Therapists' one-to-one therapeutic interactions, as well as based on professional judgements and standpoints on current TA knowledge. Thus Therapists' views helped examine and evaluate what factors in practice they deemed most favourable to the concept of the TA and in the construction of a new TA measurement scale.

The aim of constructing a new TA measurement scale was that it could be adopted throughout the duration of the therapeutic process in several ways. For example, the TA measurement scale could: a) help build knowledge and skills of trainees prior to practice or in the early stages of practice, b) in practice itself, help monitor key elements of what is currently known to assist good outcomes, and c) in supervision, be the parameter on guiding ethical practice and appropriate interventions in therapy through reflexivity and reflection (Willig, 2008). Collectively it is hoped, that by identifying intricacies of interpersonal interactions between client and therapist, this will enhance the TA.

Section C consists of a case study, which involves the researcher's work with a client from several years ago. The discussion is reflective and reflexive (Dallos & Stedmon, 2009) to enrich the reader's understanding of the interactions between the client and myself (researcher). In this case study, the therapeutic relationship which incorporates the TA as fundamental to the process of therapy, also draws on TA evidence and findings from the main study (Section B). The researcher's use of introspection is also called upon (Burnard, 2002), which highlights what beliefs and feelings she had regarding what was taking place at given times. Links between practice and theory are demonstrated throughout the session, applying several therapeutic models that are integrative in style (Corey, 2005). Counselling Psychologists draw upon many models to meet the unique and changing needs of clients. This position means being mindful of cultural diversity as well as ethical and legal implications in practice. Some of the client's demographics have been purposely changed to protect anonymity and

confidentiality. However the processes within the therapeutic encounter are unchanged. To conclude the case study, a personal reflection of the researcher's performance in this session is offered. This helped create a more informed way of practising in the future with this client and others.

Section D provides a critical review of the literature exploring a growing interest in supervision competences (Roth & Pilling, 2009). As a BPS Registered Clinical Supervisor working under the BPS Code of Ethics and Conduct (2009) and Health and Care Professions Council (HCPC) Practitioner Psychologist, it is important to help facilitate learning opportunities for supervisees (therapists and those in training) professional growth, to protect the public. In the process of practice and development there is a requirement for supervisees to be instrumental and proactive in learning more about therapeutic interactions, to ensure high standards are maintained and good outcomes are achieved. Thus, through a mutual exploration of the supervisee's practice in meeting client needs, supervision undoubtedly remains an educational and ethical experience, which draws on many elements of research and practice. This process helps ensure that a client's unique difficulties can be approached effectively and in a ways that reflect a supervisee's level of skill and developing style.

References

Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology**.** *Counselling Psychology Review, 25*(4), 19-30.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice,* 16(3), 252-260.

British Psychological Society (2009). Code of ethics and conduct: Guidance published by the Ethics Committee of the British Psychological Society: Retrieved October 10, 2012, from http://www.bps.org.uk/system/files/documents/code_of_ethics_and_conduct.pdf

British Psychological Society (2009). Ethical principles for conducting research with human participants. Leicester; BPS.

Burnard, P. (2002). *Learning human skills. An experiential and reflective guide for nurses and health care professionals.* (4th ed.) Butterworth Heinemann: Oxford.

Corey, G. (2005). *Theory and practice of counseling and psychotherapy* (7th ed.). Belmont, CA: Brooks/Cole.

Dallos, R., & Stedmon, J. (2009). Flying over the swampy lowlands: Reflective and reflexive practice. In J. Stedmon, & R. Dallos (Eds.). *Reflective practice in psychotherapy and counselling* (pp. 1-22). Maidenhead: Open University Press.

Du Plock, S. (2010). Humanistic approaches. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp.130-150). London: Sage Publications, Ltd.

Health & Care Professions Council. Retrieved April 2, 2013, from http://www.hpc-uk.org/

Kasket, E. (2012). Dialogues and debates: The Counselling psychologist researcher. *Counselling Psychology Review,* 27(2), 64-73.

Lane, D. A., & Corrie, S. (2006). *The modern scientist-practitioner: A guide to practice in psychology*. London and New York: Routledge, Taylor & Francis Group.

McLeod, J. (2003a). The Humanistic paradigm. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.). *Handbook of Counselling Psychology* (pp.140-160). London: Sage Publications.

McLeod, J. (2003b). *Doing counselling research*. (2nd ed.). London: Sage Publications Ltd.

Rogers, C. R. (1951). *Client-centered therapy*. Boston, MA: Houghton-Mifflin.

Roth, A. D. & Pilling, S. (2009). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy*, 36, 129-148.

Strawbridge, S., & Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe, S. Strawbridge, & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp.3-21). London: Sage Publications, Ltd.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: origins, Developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp. 3-22). London: Sage Publications, Ltd.

Willig, C. (2008). Discourse analysis. In J. A. Smith (Ed.). *Qualitative psychology: A practical guide to research methods* (2nd ed.) (pp.160-185). London: Sage Publications, Ltd.

Section B: Research

Therapists Views on the Therapeutic Alliance and Factors Involved in Therapeutic Alliance Measurement

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Abstract

This study explored the empirical and theoretical evidence on the therapeutic alliance (TA) which is currently said to be the best predictor of therapeutic outcome irrespective of the therapeutic approach. Despite the fact that many TA studies have been undertaken on clients' perspectives, therapists, and observers on behalf of clients, for over 30 years, there is still a lack of clarity and agreement on a precise TA definition. At a time when therapists face some politically-driven changes that requires evidence on practice, this means on the therapist's part, there is an even greater need for increased understanding on what intricacies are involved in the TA, including therapists' perspectives on how the TA is measured to support evidence. Accounts are drawn from participants from various schools of training (psychology, psychotherapy, and counselling). Collectively, these views helped in the construction of a new '*therapist awareness therapeutic alliance scale'* tested through exploratory factor analysis (EFA). A mixed qualitative and quantitative methodology was employed. The study is discussed within the context of counselling psychology philosophy and an integrative theoretical framework on practice.

Results: The TA factor structure reflected many relational elements attributed to a well known working alliance model on shared goals, tasks and an attachment bond. However, in this study, three latent factors were identified, attributed to therapists' skills: 1) relationship-building, 2) managing the process, and 3) the relational bond. Relationship-building and managing the process featured significantly higher than the relational bond in developing and maintaining the TA, indicating the TA to be more task-related. Significant findings suggest the new measure could assist practice.

Conclusion: As the driving force in therapy, the TA has implications in training (pre-practice) throughout the therapeutic process, and for reflective purposes in clinical supervision regarding best practice and continued professional development (CPD). This study has shown that more emphasis is needed on therapists' skills, in relationship building and managing how they develop and maintain the TA to protect clients, prior to, and at all points of therapy. Implications on practice are addressed and future suggestions on TA research to support practice are recommended.

Chapter 1: Literature Review

1.1 Introduction

The therapeutic alliance (TA) is a concept in psychotherapy that forms part of the therapeutic relationship (Gelso & Samstag, 2008). In an article which reviews the concept of the TA, the methods for measuring it, and its relationship with outcome, Summers and Barber (2003) describe the TA as the vehicle that steers the therapeutic process. Many empirical studies undertaken in the field of psychotherapy research on the relationship between TA and outcome have shown the TA to be the best predictor of outcome, and more than a therapeutic approach (Crits-Christoph, Connolly Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Luborsky, 1994; Martin, Garske & Davis, 2000; Mearns & Cooper, 2009; Muran & Barber, 2010; Norcross, 2002; Orlinsky, Ronnestad, & Willutzki, 2004; Wampold, 2001; Wolfe & Goldfried, 1988). Predominant studies on the relationship between TA and outcome will be reviewed in section 1.4.

Considering the high profile of the TA and the attention given to the TA in psychological literature, Muran and Barber (2010) suggest there are still many undiscovered aspects attributed to the TA. They suggest that because of the complexities involved in human relationships, relational features above the conceptual level are still to be identified. For a case in point, Green, Littell, Hamerstrom, and Tanner-Smith (2013) (who conducted a study on the protocols of systematic reviews on the therapeutic alliance and psychotherapy outcomes in young adults aged 18-34), claimed the undiscovered elements within the TA is one reason why researchers still disagree on what the TA is and how it works; moreover, Krause, Altimir and Horvath (2011) inform us that a definition of the TA has eluded us for over thirty years. Interestingly, Krause et al. (2011) whose study brings to our attention that although the quality of the TA between client and therapist is an important element in the success of treatment, and research empirically validated this proposition, "empirical validation was achieved without a consensual definition of what the alliance is, and how it is linked to other therapy processes" (p.270). This suggests implications on TA accuracy existing,

and on subsequent TA measurement, even after decades of research on its importance to outcome.

Cooper (2008) suggests the influence of therapists themselves on the TA. He reports on several studies which emphasise the impact that the therapist has on the success of therapy. For example, Cooper (2008) states that five to ten percent of the variances in a therapeutic outcome are related to differences in therapists' compared to just one percent or so that are attributable to the therapist's particular orientation. This might be because clients and therapists have diverse characteristics as well as different expectations that can influence the TA negatively or positively (Ackerman & Hilsenroth, 2001; 2003). As recommended by Muran and Barber (2010), the need to understand such diversity between clients and therapists supports the argument put forward for this study in that therapists need to recognise these differences in therapy as well as be more attuned to address and manage the challenges this can bring to prevent ruptures and disengagement (Crits-Christoph, Barber, & Kurcias, 1993; Lambert, 2010).

Uncertainty about what is involved in the TA not only has implications for quality care for clients, but for teaching and training of TA skills and for reflective purposes in clinical supervision. This is particularly pertinent in protecting clients and at a time when evidence-based practice is becoming widespread across psychological services according to the views of Jordan (2009), Lane and Corrie (2006) and guesswork on a therapist's part of the success of therapy is becoming less acceptable (Cooper, 2008).

It is crucial to remember when developing the TA and the therapeutic relationship that the process needs to be collaborative in nature, as documented by Wampold (2001). But in Wampold's opinion, therapists play an important part in the success of therapy as the professionals leading the process to a successful outcome. These, and other opinions included in subsequent sections of the literature review indicate that a research investigation involving therapists only, is not only needed to continue our goal of protecting clients in therapy to a greater extent, but to assist collaboration. An exploratory investigation that specifically considers the current position of therapists' views on the TA and the impact such views could have on clients' well-being, has to be the next dynamic in TA research. Indeed, this standpoint encourages 'reflexivity' on the

therapist's part, which is, "primarily a conscious cognitive process whereby knowledge and theory are applied to make sense of remembered reflective episode" (Dallos & Stedmon, 2009, p.4). Indeed, this reflects the major philosophical aims of counselling psychology and encourages the ongoing requirement for therapists to introspect on their personal awareness and values, and how this leads to high standards of professional practices being maintained – positions which are intrinsically linked.

For consistency in this study, the therapeutic alliance will be referred to as the TA unless in a direct quote. Service users in receipt of psychotherapy are referred to as clients or patients (if directly quoted in text). Those who provide therapy are referred to as therapists, regardless of their training school or psychotherapeutic orientation. Therapists in training are referred to as Trainees. Psychotherapy is used as a generic term for all types of therapies unless specifically stated.

To begin, an historical view on the TA is presented to orientate the reader on its origins. Opinions are formed from earlier authors in the context of the therapeutic relationship. Today many of these earlier opinions have remained at the forefront of psychotherapy and TA literature, and appear fundamental to developments in this field of research inquiry.

1.2 The Therapeutic Relationship

"The relationship between the therapist and the client is the foundation of the therapeutic enterprise and the therapist's most important means for effecting change" (Teyber & Holmes McClure, 2011, p.24).

In the 1940's, nursing theorists described mental health nursing as a therapeutic relationship. Its origins can be traced to attendants' interpersonal practices in the asylum era. It was given formal expression in nursing theory in the middle of the last century (O'Brien, 2001).

Freud's (1913) early account of a positive therapeutic relationship was viewed as a partnership by agreeing on tasks and the goals of therapy as well as emphasising the *'bond'* to help a client participate effectively and build rapport. In addition Freud

believed a client's susceptibility could cause interferences in the process, thus the need for the therapist to steer the client back on track (Muran & Barber, 2010).

According to Duncan (2002), the therapeutic relationship is central to the success of therapy along with the 'common factor' model. Over seven decades ago, Rosenzweig (1936) declared therapies like the 'Dodo-bird'. The Dodo-bird concept relating to therapy, suggests all therapies are equal. The Dodo-bird originated from a scene in 'Alice in Wonderland', where after all the characters race and everyone wins, the Dodo-bird declares 'everyone has won and all can have prizes'. Frank (1961) also proposed that a successful outcome is achieved predominantly by non-specific (common) factors within the relationship. For example, for therapy to be effective the therapist would need to be respectful, understanding, and accepting of the client. There would also be expectations that the client be open to change to help themselves overcome demoralisation and hopelessness through a benign helping relationship (Frank, 1973).

When reviewing the Dodo-bird concept and the process of therapy, Duncan (2002) emphasised the importance of the client's perceptions and contributions within their own therapy and an unequivocal link between the client rating of the TA and successful outcomes. Duncan goes on to suggest therapists need to be flexible to acknowledge the needs of a client and be able to connect and catalyse a client's effective outcomes. From this standpoint, Duncan (2002) posits that "psychotherapy abandon the empirically bankrupt pursuit of prescriptive interventions for specific disorders based on a medical model of psychopathology. Instead, a call is made for a systematic application of the common factors based on a relational model of client competence" (Duncan, 2002, p.34). Or put another way, therapists need to focus more time on building productive relationships by embracing client views on the progress of their own well-being and less time on the mastery of techniques. This type of shift in practice is also of consequence in therapeutic training programmes (Duncan, 2002) because all therapies share core features (Lilienfeld & Arkowitz, 2012).

Gelso and Samstag (2008) theorised a 'tripartite model' of the therapeutic relationship. This involves: 1) *the working alliance* (known in this study as the therapeutic alliance), conceptualised as shared tasks, goals. and an attachment bond (Bordin, 1979, 1994), and 'the vehicle through which psychotherapies are effective (Summers & Barber, 2003,

p.160); 2) *the transference and counter-transference*, a model in psychodynamic theory where a client transfers feelings that historically belonged to some other relationship onto the current relationship with the therapist, and vice versa (Jacobs, 2004); and 3) the *real relationship* defined as "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (Gelso, Kivlighan, Busa-Knepp, Spiegel, Ain, Hummel, Ma, & Markin, 2012, p.495).

Another theory based on the common factors model, described as 'the therapeutic pyramid', involves a synthesis of techniques, alliance, and way of being, and shows the therapeutic relationship as: "being influenced by at least three components: 1) the client's characteristics and personal attributes; 2) the relationship between the therapist and the client, including the therapeutic alliance; and 3) the person of the therapist, including the therapist's facilitative conditions and the therapist's interpersonal attributes and style" (Fife, Whiting, Bradford, & Davis, 2013, p.4). Although these definitions suggest that the therapeutic relationship is rightly seen in a professional light, for example, how therapists might structure the process of therapy, it is clear from the perspective of Fife et al. (2013) that some of its components are innately personal.

Finally, it should be noted that despite the above claims on the 'Dodo-bird' effect on outcome, some argue that certain therapeutic approaches like cognitive behavioural therapy may be more effective than others, for example, in the treatment of post traumatic stress disorder (PTSD) or obsessive compulsive disorder (OCD) discussed by (DeRubeis, Brotman, & Gibbons, 2005). In these instances, there seemed a tendency to rely more on the therapist's technique rather than the interpersonal relationship. Yet overall, "Evidence confirms that specific techniques contribute less to therapeutic effectiveness than the quality of the relationship" (Strawbridge & Woolfe, 2010, p.5).because the relationship seems integral to the success of the therapeutic encounter (Bordin, 1994; Lambert, 2004; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). Therefore whether the involvement of the therapist is technical or relational and to a greater or lesser extent, the relationship can account for as much as thirty percent of the variance in outcomes (Cooper, 2008) and the TA is evidently a contributor.

1.3 Conceptualisation of the Therapeutic Alliance

Broadly speaking, the TA refers to the collaborative relationship in working through treatment goals (McEvoy, Burgess, & Nathan, 2014). More specifically, Foreman and Marmar (1985) describe the TA as, "the observable ability of the therapist and client to work together in a realistic, collaborative relationship based on mutual respect, liking, trust, and commitment to the work of treatment" (p.922).

Developing from the psychoanalytical era (1913) and Freud's comments about the therapeutic relationship on positive feelings between doctor and patient (Summers & Barber, 2003), Sterba (1934) initially introduced the term 'ego alliance' and referred to the need for a positive relationship between the patient's ego and the therapist's analysing ego. Sterba stressed the importance of the client's ability to work towards the success of the intervention and believed the client to have an observing capacity of their rational self. In this model, the therapist would act upon the irrational forces of the client's transferences and defences (Muran & Barber, 2010). Zetzel (1956) on the other hand, emphasised the non-transferential impact on the relationship and viewed the client as following the therapist and making their own interpretations (Ardito & Rabellino, 2011). That said, Zetzel still acknowledged that transference and alliance overlap (Safran & Muran, 2006).

Similar to Freud's (1913) beliefs on a therapist's ability to guide and support clients at times of susceptibility, Rogers (1957) also contended that the therapist's role is a prominent, active facilitator in the therapeutic process. He proposed a positive TA was achieved in the relationship by the therapist applying three main core conditions: 'empathy', 'congruence', and 'unconditional positive regard'. Greenson (1967) later conceptualised the 'working alliance' model and (like Sterba) acknowledged the '*work'* that needed to be done in the dyadic partnership in therapy. However, in Greenson's model, the emphasis seemed to be client-led (Baillargeon, Coté, & Douville, 2012) rather than therapist-led, which seemed to be the case in Sterba's interpretation.

Bordin (1979) developed upon Greenson's model of the working alliance, and also acknowledged that client and therapist are both 'agents for change' in the therapeutic process. Bordin viewed the TA as the degree to which the dyad (client and therapist)

engage in collaborative and purposive work. In his seminal article Bordin (1979) suggested two different bond concepts. "One is the overall experience of liking, trust and respect that develops during therapy. The second is the requirement that the bond be strong enough to undertake the particular tasks of therapy, a requirement that would vary across types of therapy" (Hatcher & Barends, 2006, p.296). In Bordin's (1979) model, tasks, goals, and attachment bonds act upon one another to build and maintain the TA (Andrusyna, Tang, DeRubeis, & Luborsky, 2001). This could account for Bordin's later description suggesting the TA is not a specific intervention *per se*, but rather it facilitates the use of specific therapeutic interventions at a superordinate level (Bordin, 1994).

Hatcher and Barends (2006) explored the strengths and shortcomings of Bordin's (1979) TA theory, to capture the collaborative aspects of the therapeutic encounter. In this paper, the authors discuss two core assumptions: first the TA is concerned with the purposive work, and second, the TA is interpersonal, developed and expressed as a reciprocal, interactive relationship. Hatcher and Barends (2006) propose two conceptual levels in therapy; these consist of technique (activity) and the TA (a way to characterise the activity), distinguishing technique as a component of therapy and the TA as a property of the components of therapy. Thus unpacking the reciprocal alliance-enhancing actions of therapist and client through task and sequential analyses would be of real value in deepening our understanding of alliance in therapy (Hatcher & Barends, 2006, p.297). The authors concluded that the TA is therefore not reducible to clients' experiences although clients' experiences can provide a reasonable estimate of the TA. For example, exploratory findings on studies of cognitive therapy for depression, found clients' attachment style and their ability to competently form social relationships may make it difficult for some clients to foster a strong TA (Baldwin, Imel, & Wampold, 2007). This study is discussed in more detail in the section below.

1.4 Therapeutic Alliance and Outcome

Most of the TA literature between TA and outcome has applied mainly to adult samples (Green et al., 2013). However, the TA has shown an important relationship to outcome with young people below nineteen years old (McLeod, 2011). For example, Faw,

Hogue, Johnson, Diamond, and Liddle (2005) found in their study of 51 at-risk African American 11-14 year olds, involved in family substance abuse counselling, that in young people, it seems there may be more emphasis on relational TA factors than in adults because of the younger client's underdeveloped cognitive abilities which could limit work on shared goals and tasks. Another dynamic which highlighted the TA with older clients in a cognitive behavioural therapy (CBT) study on depressed older adults (Karlin, Trockel, Brown, Gordienko, Yesavage, & Taylor, 2013) also showed links to TA and outcome.

Key points which arise from these studies, included the importance of the TA relational bond (for older clients) being maybe about loss or reduced social life and the bond of younger clients (albeit for different reasons) indicating that the relational aspects of therapy are more important than the therapy itself, at least in early therapy (Karlin et al., 2013). Due to the nature of the current study which focuses on the views of therapists on the TA, to help establish further understanding of the concept and how it could be measured in developing best practice rather than re-appraising links between TA and outcome, an extensive analysis of this type of study lies beyond the scope of this review. However, it is hoped that by introducing a few of the most-documented TA and outcome studies, the reader can gain understanding on the implications of psychotherapy and outcome research and that due diligence remains key to how we proceed with future investigations on how they are evaluated.

A review of the literature has shown that the most well-documented and prolific studies (discussed in chronological order) on TA and outcome, are those undertaken by Horvarth and Symonds (1991), Martin et al. (2000), Horvath and Bedi (2002), Baldwin et al. (2007), Horvarth et al. (2011) and Del Re et al. (2012).

Horvarth and Symonds' (1991) research involved 20 studies published between 1978 and 1990 on the quality of the TA to therapy outcome using meta-analytic procedures. Each study contained on average 40 participants. Meta-analyses can be used to examine the relative efficacy treatment over many studies. "Meta-analysis provides a quantitative test of the hypotheses and avoids conclusions, based on salient but unrepresentative studies (Wampold, 2001, p.75). Overall, the quality of the TA was the most predictive

of treatment outcomes based on clients' assessments, less so of therapists' assessments, and least predictive of observers' reports. This study showed that there was little correlation difference in TA and outcome in the early and late stages of therapy (.31 and .30 respectively). The overall TA correlations for multiple sessions dropped to .17, fitting the theoretical pattern with the conceptualisation of the TA where within the therapeutic process the relationship goes through a period of break and repair. What remained inconclusive in the Horvath and Symonds' (1991) report was causality. For example, although in this study a good TA resulted in a good outcome of therapy, it may be that clients who experience good progress subsequently form a good TA opposed to those who do not, i.e., outcome causes the TA rather than vice versa.

Martin et al (2000) conducted another meta-analysis to update the previous one. The authors examined links between alliance and outcome involving 79 studies that were conducted over an 18-year span, with 30 studies available before 1990 and 49 studies available between 1990 and 1996. "Of these studies, 58 were from published sources and 21 were unpublished doctoral dissertations or master's theses. The mean sample size was 60.39 patients (SD = 64.64), and the average length of treatment was 22.18 sessions (SD = 18.76). The studies were reported to have had heterogeneous samples which included male and female participants. Approximately two-thirds of the patients were female and the majority were from outpatient services. There were several presentations including depression, substance misuse, bereavement and eating disorders. The mean number of therapists per study was 20.22 (SD = 19.99) and the average amount of therapist experience was 8.10 years (SD = 5.23)" (Martin et al., 2000, p. 443). In this study, the authors found the relationship between TA and outcome does not appear to be a function of the type of therapy practised, nor did the length of treatment influence results. They also found little difference in whether the research was published or unpublished, or the number of participants in the study.

The coding techniques in the Martin et al. (2000) study were undertaken by graduate and undergraduate researchers (less-experienced researchers) which involved the coding of variables, for example, type of article, number of clients or therapists in the sample, diagnosis of clients, therapist affiliation and experience. To account for which studies should be involved in the meta-analysis, there appeared good agreement on the selection

of studies between raters (87-92%) as well as with the researchers. To help reduce *a priori* effect on effect sizes, such effects were clearly accounted for, and stated in five stages (see p.442-443). The findings of this study tentatively support the findings of Horvath and Symonds (1991) that a 'modest but reliable' relationship exists between alliance and outcome, but the TA was viewed as a non-specific important factor.

The overall TA-outcome correlation was .22 and therefore adequately depicts the relation of TA and outcome. However, Martin et al. (2000) point out that caution is still needed on this correlation and suggested "it would take 331 studies averaging null results to reduce the correlation of alliance and outcome to $p < .05$". As Hays (1994) points out, finding a significant effect once at $p < .05$ means that there is a 1 in 20 chance that the effect represents a Type I error (i.e., reporting an effect to be significant when, in fact, it does not exist). However, if the same effect is found twice on separate occasions at $p < .05$, this means that there is a 1 in 400 chance that the effect represents a Type I error. Thus according to Hays (1994), replicating an effect can greatly increase our confidence in the reliability of that effect.

The meta-analysis on adult TA and outcome undertaken by Horvath and Bedi (2002) showed a correlation of .21 which also indicates the TA accounts for a modest 5% of the variance in outcome. Over the course of the reported TA and outcome studies, a moderate but reliable association between good TA and positive therapy outcome was found to be between 5-8%.

A study by Baldwin et al. (2007) explored the relative importance of clients' and therapists' variables on the TA and outcome involving 331 clients and 80 therapists with an average caseload of 4.1 clients. This study showed it is the therapist's ability to forge a collaborative relationship with the client that is predictive of outcome and that the therapists' variability in terms of outcome is due to therapists' contributions to the TA. However, the results were based on just one measure of outcome and alliance, and ratings were only rated by clients. Although in this study findings highlighted the importance of the therapist's role and indicated better therapists tend to form better alliances, it is important to note participants (clients) were not randomly assigned to therapists. This suggests that in helping to achieve a good outcome, selection biases

could have influenced results on the variability factors on the quality of the TA whereas in reality, clients are not privileged in selecting their own therapist (unless within the private sector).

Del Re et al. (2012) examined whether research design, type of treatment or the authors' allegiance variables alone, or in combination, moderate the relationship between alliance and outcome. The authors found that there was little difference in impact whether on individual or combined variables. What was interesting was those who appeared to show more allegiance to the TA than those who did not, did show higher correlations on early outcome. This outcome suggests that a belief in the process might be another variable that can influence the TA and subsequently the therapeutic relationship. According to Del Re et al. (2012), the above outcome could also help identify the influences between client/therapist relationships and provide a clearer model that will be beneficial in clinical training to help strengthen new therapists' capacity to be more effective with clients. These authors propose, "more research is needed on process variables related to outcomes to help disentangle the within-and between-therapist contributions to the process variable" (p.647).

Since these studies were undertaken and meta-analyses performed, the introduction of the 'AMSTAR' criteria has been developed to assess methodology quality. The AMSTAR contains 11 items identified by exploratory factor analysis performed on over 150 studies to identify the core components of 'review quality'. (For details of the AMSTAR criteria, see appendix 26 of this study). In one of these studies, Horvarth et al. (2011) involved a meta-analysis of 30 different measures on alliance and outcome. According to Green et al. (2013), "using the AMSTAR criteria, the four meta-analyses performed on studies of adults (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Horvath, et al., 2011; Martin et al., 2000) appear to lack many of the elements of rigorous and valid research syntheses. For example, none of the four meta-analyses reported that they had a public, *a priori* design, duplicate study selection and data extraction, or formal evaluation of study quality" (p.5). That said, a review by the researcher of this study did show that Martin et al. (2000) had accounted for some priori effects, but all of the areas reported by Green et al. (2013) are important factors that need consideration when reporting findings on future studies.

To conclude the discussion on TA and outcome and measurement of the TA presented here, overall, these findings bring to our attention some interesting findings on the many variables involved that affect outcome from both clients' and therapists' perspectives. This highlights for the future the importance on standardising methodological procedures (such as those used in the AMSTAR criteria) when undertaking systematic reviews and meta-analyses. The use of this type of procedure demonstrates a positive step forward in our approach to study selection, evaluation of studies and outcomes in research to help reduce methodology flaws in support of good therapeutic practice.

While the collaborative agreement on treatment in building the therapeutic relationship is, quite apparent, early TA definitions identify with a client's ability to engage and 'work' in therapy, the reviewed perspectives still tend to lean more towards the need for a therapist's skills in therapy. As there is no satisfactory answer on what makes therapy effective, since the 1980's, a number of instruments have been developed to measure the TA (Hanson, Curry, & Bandalos, 2002).

1.5 Therapeutic Alliance Scales and Factors Currently Involved

In general, rating scales have been around for many years. Countless articles on rating scales have followed the seminal work of authors (Freyd (1923; Thurstone & Chave, 1928); Likert, 1932; Rohrmann, 2003). The details of these works lie beyond the scope of this study. Rating scales represent attitudes, values, opinions, personalities, and descriptions of people's lives and environments (Spector, 1992). Data collected from rating scales have helped governments make decisions on problems in society (Sajatovic & Ramirez, 2003).

Various opinions have emerged on TA measurement over the years. For instance, TA measurement scales were initially developed for theoretical and evaluation purposes rather than a day to day clinical process tool (Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003). Moreover, empirical evidence has shown TA scales tend to be used for study-specific research (Cahill, Barkham, Hardy, Gilbody, Richards, Bower, Audin, & Connell, 2008). Current understanding of the TA has been enhanced through widely-used and rigorously tested TA scales (Marmar & Gaston, 1988; Horvath & Greenberg, 1986; 1989; Luborsky, Barber, Siqueland, Johnson, Najavits, Frank, &

Daley, 1996). Different versions of TA scales have evolved from aspects of what is believed to represent the TA, and over the years, factor analysis is usually performed to detect underlying TA dimensions (Niemeyer, 2004). Just a few examples include introducing shorter versions of original scales (Tracey & Kokotovic, 1989) and making amendments to items that explicitly assessed early symptom improvement rather than the TA itself (Luborsky et al., 1996). Testing and retesting of reliability and validity (Hanson et al., 2002) have also led to amendments.

The Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) and California Psychotherapy Alliance Scales (CALPAS) (Marmar & Gaston, 1988), attempt to measure the theoretical conceptualisations of the TA as developed in Bordin's model (Elvins & Green, 2008). The 'Vanderbilt project' developed process scales focused on client-rated aspects and therapist-rated aspects (Suh, Strupp, & 0'Malley, 1986) which offer a blend of alliance constructs. For a detailed discussion on Vanderbilt Process Measures including the Vanderbilt Psychotherapy Process Scale (VPPS) and the Vanderbilt Negative Indicators Scale (VNIS), see Suh, Strupp and O'Malley (1986) in 'The Psychotherapeutic Process' (Greenberg & Pinsof, 1986). See also, 'Change Process Research' on how Elliott proposes change takes place in therapy (Elliott, 2010).

A study by Cecero, Fenton, Nich, Frankforter and Carroll (2001) focused on the psychometric properties of six TA measurement scales: California Psychotherapy Alliance Scales; Penn Helping Alliance Rating Scale (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983), Vanderbilt Therapeutic Alliance Scale; and the Working Alliance Inventory – therapist, client, and rater versions, across three therapeutic conditions with a small sample of depressed females. This study was developed from a similar study (Tichenor & Hill, 1989) cited in Cecero et al. (2001).

In the Cecero et al. (2001) study, a sample of 60 substance-dependent individuals were involved in a randomised clinical trial of three psychotherapies. Six measurement scales had high levels of internal consistency (Alpha ranges between 0.77 - 0.90) and the psychometric properties were largely comparable, in which case, it was suggested by Cecero et al. (2001) that therapists could choose any one scale for process measurement. However, when discussing limitations, Cecero et al. (2001) make particular reference about the extensive training needed beyond the eighteen hours provided prior to rating

the measures as observers. In this study, for each of the six raters (only three of which were qualified psychotherapists and three still in training) this proved more difficult for participants in the study than recommended by Tichenor and Hill. (see Tichenor and Hill (1989) for more details). This suggests that the use of measurement scales in therapy is not just about ticking boxes, but is a task that requires a great deal of skill to achieve adequate reliability. As a case in point, this is noteworthy especially where observations on therapy are more likely to take place in training environments or for research purposes in order to gather evidence. In both instances, the accuracy of TA measurement in less-skilled therapists could be questionable.

To reduce the time involved for therapists to complete longer scales due to their busyness as practitioners, Miller, Duncan, Brown, Sparks, and Claud (2003) discuss the use of four-item ultra brief scales, the Outcome Rating Scale (ORS) developed to measure the outcome of therapy on a routine basis and the Sessional Rating Scale [SRS] to help measure the TA in practice (Miller, & Duncan, 2000). Although a lot of the literature on both these measures has involved the authors themselves, as a brief scale, Campbell and Hemsley (2009) evaluated the validity of the ORS and SRS in psychological practice, by comparing the outcome assessment data obtained from these measures with those from longer, more established measures. These included the OQ-45, the Quality of Life Scale (QOLS), the Depression Anxiety Stress Scale-21 (DASS-21), the General Self-Evaluation Scale (GSE), and the Working Alliance Inventory (WAI) (12 item) patient version. In support of TA measurement, the authors report that the SRS has good clinical utility with primary care clients. However, due to the small sample size of participants (clients) (N = 65) which were recruited through GP practices, they suggest caution on clinical use of the brief measures, with more severe psychological or psychiatric presentations to be noted, and that further confirmatory analysis should be performed on both longer and brief measures to establish evidence based on effectiveness rather than simple efficacy.

Hatcher and Barends' (1996) study involved factor analysis on three TA measures (WAI, HAQ Questionnaire and CALPAS Scales. They state "there has been little evidence to support the theoretical dimensions that underlie the measures". Their analysis of the Working Alliance Inventory, California Psychotherapy Alliance Scales,

and the Helping Alliance Questionnaire indicated that after removing the large general factor, only two of the six factors were identified using the principal component analysis, "Confident Collaboration (Confident Collaboration describes the clients' confident investment in a treatment that feels promising and useful to both parties) and Idealized Relationship, correlated with patients' estimate of improvement (rs = .37 and -.23, respectively; p <.001)" (Hatcher & Barends, 1996, p. 1326). Further, "the total scores on the three measures correlated highly: CALPAS and WAI, r = .85; CALPAS, and HAQ, r = .74; WAI and HAQ, r = .74 (p<.0001, N= 231), indicating the presence of a strong general factor." (p.1328). Thus, Hatcher and Barends (1996) reported that TA scales may be conceptually different but are also overlapping in constructs. For example, Bordin's (1979) model, suggests a factor structure comprising one general alliance (the relationship between client and therapist) and three secondary factors: shared goals, tasks and attachment bond (Andrusyna, Tang, DeRubeis, & Luborsky, 2001).

Luborsky (1976) cited in Horvath and Luborsky (1993), conceptualised a related bipartite division of two factors, 'Type 1' signs (the client's experience where the therapist provides the help that is needed) and 'Type 2' signs (the client's experience of treatment as a process of working together towards goals). Gaston (1990) on the other hand, proposed a multidimensional model that consisted of four factors, 1) the client's capacity to work purposefully in therapy, 2) the client's affective bond with the therapist, 3) the therapist's empathic understanding and involvement, and 4) agreement between client and therapist on goals and tasks of treatment. Hougard (1994) also developed a bipartite conceptual model of the TA consisting of two factors 'personal alliance' and 'task-related alliance' (Elvins & Green, 2008).

Andrusyna et al. (2001) studied the TA in Cognitive Behavioural Therapy (CBT) using the Working Alliance Inventory-Observer Short version (WAI-O S) which took place with 94 clients in the Jacobson, Dobson, Truax and Addis (1996) study. The clients' average age was 39 years, the female-to-male ratio was approximately 3.5 to 1, and more than 80% of clients were caucasian. In their study, Andrusyna et al. (2001) postulated a two-factor alliance (agreement/confidence and relationship) over the general one-factor alliance described by Bordin (1979). Despite their findings, the

authors advocated that Bordin's model still remains popular in literature but simultaneously suggested a need for further clarification of this therapeutic construct in CBT based on some limitations in their study. For example, the methodological procedure of obtaining data included audio-taped observations which limit observer visual interactions (body language and facial expressions) in identifying items related to the WAI-O S. The short version of the WAI-O S also limited the items which were loaded onto the factors whereas the longer version could have supported the evidence in conceptualising a CBT alliance.

Elvins and Green (2008) on the other hand, having undertaken a systematic review of over 50 TA measurement scales to help clarify the diversity amongst measures and to address treatment alliance, posit the need for diversity with no unifying model. For instance, a factor analysis on the development of the 'Adolescent Therapeutic Alliance Scale' (Faw et al., 2005) showed that 'one construct' seems to predominate in adolescent alliance despite reflecting Bordin's concept on shared goals, tasks and an attachment bond, and, inclusion of 'Patient contributions' versus 'Patient-Therapist contributions' in the analysis. A reason given for this was social cognitive abilities of adolescents in recognising their psychological problems might mean their opinions on shared goals and tasks differ from that of their therapists. In this example, the authors suggest adolescents may be more influenced by the 'bond' component of the TA which could account for a one factor construct (Faw et al., 2005).

Finally, TA measurement still predominantly favours common factors rather than technical factors or specific factors (Summers & Barber, 2003; DeRubeis et al., 2005; Elvins & Green, 2008; Strupp & Hadley, 1979) in the therapeutic relationship, because the TA is a major component of successful therapy (Frank & Frank, 1991; Wampold, 2001). Thus "Overall, current alliance scales take an empirical and descriptive approach to measuring notional alliance constructs. It is a matter for future work as to whether alliance measurement can be made more specific or whether part of the strength of the TA construct is in its generality" (Elvins & Green, 2008, p.1179). However, as noted above, and worthy of a reminder, evidence demonstrated on the factor structure relating to adolescent alliances (Faw et al., 2005) has shown it can differ to that of adult clients, in that it reflects current cognitive abilities yet, similar to the needs of older clients,

adolescents seem to value the relational aspects in therapy. Thus, caution should prevail if applying Bordin's popular definition in alliance-building on matters of task and goal-setting with younger and older clients. Keeping this in mind, consideration should also be given when working with people with neurological deficits – young and old.

In the previous sections the value of the therapeutic relationship has been discussed, origins of the TA investigated, and elements involved in how the TA is constructed from the perspectives of different researchers in the field of TA literature. This led to some debate on whether the TA is indeed more client or therapist led. Not surprisingly, this lack of clarity contributes to the complexities in TA measurement scales and the types of factors involved that are needed for therapists to accurately substantiate evidence-based practice.

In the next section, the review develops these areas by considering how the TA is currently rated, with considerations given to the different perspectives of client and therapist raters, accounting for some comments on observer ratings by Cecero et al. (2001).

Rating the TA can involve a client, therapist, or observer. Explanations are given on how each viewpoint can affect accounts of what takes place in therapy. The review then considers characteristics and relational factors that attach to the TA. The final sections explore how the TA has evolved in psychotherapy literature over the last few decades and its current usefulness in therapy which each, and all, affect the dynamics on how and what therapists need to do in the course of their practice. A summary of the review is presented and leads to the study rationale and its relevance to counselling psychology.

1.6 Rating the Therapeutic Alliance

The TA is either rated by the client, therapist, or observer (Hanson et al., 2002; Summers & Barber, 2003). However, an empirical review of the conceptualisation and measurement of the TA discussed by Elvins and Green (2008) showed clients to be the most common raters in all TA scales. This is followed by therapists and then by observers. In the early stages of TA measurement, observer judges tended to predominate and would focus on the client's perception of the therapy or the

collaborative relationship (Niemeyer, 2004). Although not substantiated, this could be one reason why some suggest that clients understand the TA more than therapists.

Bachelor (1995) conducted 'phenomenological content analyses' on the therapeutic relationship (from the perspective of the client), which involved 34 predominantly female French-speaking participants over three phases of therapy (beginning, middle and late). Bachelor's study involved clients' expectations of therapy prior to therapy and their opinions on the TA while in therapy. Bachelor also discussed the types of TA preferences (typologies) suggested by clients. These included nurturant TA = 46% (supportive and helpful) insight-orientated TA = 39% (professional knowledge on the process) and collaborative TA = 15% (mutual decision-making). Interestingly, during the early phase of therapy which was stated between sessions one to five, nearly half of the sample (47%) preferred the nurturant TA over the other types, these being 32% and 21% respectively.

These results suggested that clients might prefer different types of TA at different phases of therapy, so it is important for the therapist to be attuned to the phenomenological and idiosyncratic qualities of clients' appraisals of the TA. Second, therapists need to be mindful that some clients might look to them for more support in the early stages of therapy as opposed to later stages where they feel they can become more involved in the decision-making process on the tasks and future goals of therapy. When considering these client changes across therapy, the therapist also needs to be aware that clients' views may become inconsistent with the therapists' views on the TA. As such, what a therapist thinks about the therapeutic relationship and how it is developing, could be irrelevant if the client is not thinking the same as the therapist.

While clients' views on the TA offer much more food for thought for therapists than those of their own, it is noteworthy that in the Bachelor (1995) study, males were underrepresented and might view TA types differently throughout the course of therapy to female clients.

Bachelor and Horvath (1999) who discussed empirical studies on the therapeutic relationship posit that client ratings of the TA are far better predictors of outcome than

therapist ratings and suggest that therapists need to be more attuned with the TA because of the impact this has on client change.

A study by Hatcher (1999) focused specifically on therapists' views using two measures: the CALPAS and the WAI. Component structures were identified in one sample (N = 251) and confirmed in a second (N = 63 therapists, 259 clients) using Perfect Congruence Analysis. Four components were found in the WAI: Shared Goals, Bond, Goal & Task Disagreement, and Therapist Confidence in Treatment. Data were analysed using principal component analysis. The results concluded "...that therapists are in fact attentive to the patient's engagement in and commitment to treatment, and this aspect of the therapist's evaluation of alliance is most linked to key patient alliance variables such as 'confident collaboration' (described above). However...therapists' relative emphasis on patients' contributions to collaboration, and the apparently quite discrepant judgments about the quality of the interpersonal bond, point to some possible sources of misperception" (Hatcher, 1999, p.419). The strength of this study lies in its portrait of the therapists' sense of the clients' progress in treatment, but its limitations show that psychodynamic therapists are the major group in both samples. For example, the emergence of two goals and task factors might not be highly valued by dynamic therapists and by the salience across groups of the therapist's perception of the client's collaboration as opposed to other approaches, such as in CBT.

Bachelor and Salamé (2000) highlight two studies on therapists' and clients' perceptions of TA variables, which tentatively support some individual differences in perceptions across the course of therapy. The goal of their study was to track facets of the TA (such as helpfulness, joint work efforts or positive attitude) across therapy from the perspectives of clients and therapists, using different TA measures and different assessment times. Study one involved 27 white therapist-client dyads, from a French university consultation service. Clients included 20 female and seven male participants with an average age of 30.15. The sample was drawn from 47 dyads from a previous study. However, no effects of the analyses of that study were reported in the Bachelor and Salamé (2000) study. Clients were seen by 17 first-year trainee clinical psychologists on a masters' programme. Presentations were stated as moderate, and 14 clients had received therapy previously. The mean age-range was 30.15. The majority of

therapists worked from the humanistic paradigm (70%) and the remaining, bioenergetic (analysis of body and mind) = (18%) and psychodynamic = (12%). TA ratings were taken by assistant researchers at the third, tenth and next to last sessions. Therapists completed the TA measures to correspond with the timing of the clients, although this did vary according to client cancellations or other delays (not specified) whereby the adjacent session rating was used. Preliminary analyses were conducted to assess the effect of the number of sessions on participants' TA ratings. The length of treatment varied resulting in a range in the number of sessions across clients. The researchers then decided to divide the participants into two groups of client/therapist dyads (how this was determined is not clear). A mean of therapy sessions from both groups (n=14) and (n=13) respectively, was then taken, as a measurement on average levels of the individual alliance characteristics, either client- or therapist-rated, which did not differ significantly between the two groups, regardless of assessment time. These results showed that treatment length did not influence participants TA perceptions.

Study two involved 30 white French-speaking dyads (clients and therapists) from three different sites of the same university consultation service stated in study one. The sample included 18 females and 12 males. The mean was age 35.10. The therapists were recruited individually or at staff meetings. The therapists ranged from licensed psychologists to two voluntary helpers who had no formal counselling training. Therapists were asked to recruit from incoming clients to the service. In this study, clients were asked by therapists at the fifth and tenth session to rate the TA which was issued to them in a sealed envelope and subsequently returned sealed to protect anonymity. Between the fifth and tenth session, the clients' ratings stabilised on factors of warmth, helpfulness and support from therapists as well as their own positive attitude to change.

The therapists' TA perceptions were found to shift more prior to the tenth session, and after the tenth session, the therapists' TA seemed to stabilise, whereas the clients' perceptions changed before and after the tenth session. However, as reported in study two, most TA perceptions tended to be stable between the fifth and tenth session for both clients and therapists. The authors suggested many facets of therapy attributed to the TA (for therapists) that may stabilise at the fifth session.

In study one, aggregate results drawn from group ratings showed that the clients and therapists held similar views on the TA, within the respective dyads. However, the findings revealed that clients and therapists did not share the same views regarding the features of the relationship over time. In study two, it was shown that single assessments could account for the many facets of TA perceptions as opposed to those viewed over the entire course of therapy, which probably accounts for different things being experienced at different times, as opposed to an overall assessment. For this reason, early ratings on the TA did not predict appraisals of later or near-to-end sessions. The findings in study one are therefore tentative because the rating of the TA from the clients' and therapists' perspectives was inconsistent through the cancellation of sessions and other delays in acquiring ratings. As the authors point out, aggregate scores can mask important individual differences in perceptions of the TA. This means more emphasis is needed on individual (client and therapist) TA perceptions across the duration of therapy and would add to our understanding on the differences perceived within the therapeutic relationship. In study one and two, male views were underrepresented and most of the participants (therapists) in both studies were inexperienced with two participant therapists not having any counselling training at all (albeit, they were under supervision on practice). For these reasons, the findings in both studies should be considered cautiously.

Some of the findings in the Bachelor and Salamé (2000) on reasons which may account for different perspectives on how clients and therapists rate the TA could be that each is rating different aspects of the alliance. For example, clients may rate the TA by comparing relationships outside therapy, whereas therapists may rate the TA by comparison with other clients (Niemeyer, 2004). Second, clients might judge the TA based on their perceptions of the therapist's friendliness, warmth, and understanding as discussed by Ackerman and Hilsenroth (2003), whereas therapists and observers might judge the TA strength theoretically on agreed goals and tasks, and the assumed responsibility by the client for their own progress, documented by Cecero et al. (2001).

An article by Ardito and Rabellino (2011) reviewed relevant literature on the relationship between the therapeutic alliance and outcome in psychotherapy, and suggested that differences on the views of the TA could occur because clients tend to

rate the TA subjectively according to their past experiences and individual expectations, whereas therapists might rate the TA based on their professional judgements on the process in relation to their professional experiences.

Elvins and Green (2008) propose that client's evaluations of the TA tend to remain stable, whereas therapists and observers change over the course of therapy (A further study by Bachelor (2013) also found that therapist views on the TA are not necessarily shared by clients. Bachelor (2013) sought to gain a closer understanding on how client and therapist perceptions differ and overlap on the participants' own definition of the TA. Bachelor also examined the importance to the therapeutic outcome of cross-measure TA constructs. Measures involved the WAI, CALPAS and the HAQ. The procedures on recruitment in this study reflected those of Bachelor and Salamé (2000). Moreover, some of the therapists in the 2000 study also participated in the rating of alliance measurement. Both studies were based on the Hatcher and Barends (1996 and Hatcher (1999) studies discussed earlier. Findings on therapists' perceptions on the TA were similar to those reported by Hatcher (1999) and cross-measure client and therapist constructs were similar to the findings in the Hatcher and Barends' (1996) study but with the exception of the participants' concept of collaboration. For example, the Bachelor (2013) study "viewed collaboration more in terms of a shared understanding of, and mutual efforts towards, the work of therapy rather than commitment on the part of the client and joint confidence about the usefulness and helpfulness of the work" (Bachelor, 2013, p.131). In clinical practice (real time sessions), therapists are nowadays (generally) recommended to explicitly address techniques and work on strategies. Collaboration and what this actually means to clients, is clearly something that requires more clarity from clients to support therapists' understanding.

On concluding the limitations on this study, Bachelor (2013) recommended that more assessments of the TA be conducted over the duration of therapy as opposed to the one assessment taken in this study. What is of interest in the Bachelor (2013) study is that other limitations acknowledged by the author included a small sample size, lack of male participants, use of white participants only, and use of inexperienced therapists, all of which were similar demographic limitations reported in an earlier study by Bachelor and Salamé (2000). Bachelor and Salamé (2000) recommended more research with

larger samples and diverse participants on the perceptions of the TA. To this end, while the replication of studies can always support new evidence, it is also important to vary procedures with different samples to enhance the quality of studies in gaining new evidence to assist practice.

Bedi and Duff (2009) developed upon the Bachelor (1995) study (stated above) but added a further TA type (personal and professional TA). A summary of each TA type was provided for participants. Bedi and Duff conducted two studies which predominantly included females in both studies and where most of both samples classed themselves as European. In their studies, the TA preference-type was rated for the overall duration of therapy unlike Bachelor (1995) whose study analysed data across the three phases (beginning, middle and late). The findings suggested that clients may view the TA as multi-dimensional and not attribute a particular alliance-type in a singular format. For example, some clients might view TA types as both personal and professional or nurturant and personal or nurturant and professional. The authors concluded that in this study, there was no methodological sound rationale to suggest that self-reports by clients on their TA preferences will improve outcome. However, they stress the importance of client feedback still leading to improved outcome.

A deconstruction of the TA following a review of five studies (Krause et al., 2011) aimed to clarify a definition as perceived by clients and therapists, and then to compare and contrast perceptions, through frequently used TA measures. The studies involved clients and therapists in a semi-structured interview about their experiences in therapy, probes about the relationship, change processes and the overall evaluation of change. The data was based on open questions to help obtain a deeper elaboration of therapists' and clients' experiences. While the clients and therapists noted that changes in the process helped the TA, the differences most noted were that clients were putting greater emphasis on the therapists' expertise and experience in the earlier stages of therapy, whereas, therapists put more emphasis on the clients' commitment and collaboration. Although both clients and therapists commented on the affective bond and put less emphasis on goals and tasks, these authors (like others) posit that therapists need more understanding of what is involved in the TA in order to protect clients.

Being able to accurately interpret client conflict early on in therapy can improve the TA later on in treatment (Crits-Christoph, Barber, & Kurcias, 1993). The afore-mentioned development of the SRS TA scale (Miller & Duncan, 2000) was constructed to help busy therapists obtain more reliable clinical data through an ultra-brief TA measurement tool. Due to some views that without the aid of measurements, therapists are not skilled at rating the TA (Andrews, 2007), Cooper (2008) also suggests therapists can get it wrong. For example, Dew (2003) cited in Cooper (2008) claimed ninety percent of therapists put themselves in the top 25 per-cent in terms of service delivery (this may not always be the case) suggesting therapists beliefs on how they perform in therapy could be misleading in terms of outcomes and another indication that more research on how therapists examine the TA is necessary. To add to this lack of clarity, according to Cooper (2008), client feedback may not always be reliable when reporting the usefulness of therapy. That is, if a client has had a negative experience and therapy has been unhelpful, they may report the opposite (Cooper, 2008). This suggests that if therapists are more aware and better prepared to accurately recognise their own attitudes and beliefs about the TA, this will surely support the needs of their clients in developing and maintaining a positive therapeutic relationship.

Studies on rating the TA have shown that the process can be complex because different constructs are being measured for different reasons and by people in different roles. Over the last two decades there has been an emphasis on technique rather than therapist skills, and this may well be due to the availability of funding on research for evidence-based therapies (Lebow, 2006). This might well confound the therapist position on what is actually involved in the TA and TA measurement.

Second, if therapists tend to have different perspectives on the TA than that of clients, and clients find it difficult to be honest about their experiences in therapy (Cooper, 2008), this could affect the reliability of client ratings in regards to what has helped in therapy and what has not. Therefore, in obtaining accurate and reliable TA data, Duncan, Miller and Sparks (2004) propose an emphasis on heightening awareness on the processes involved in the TA is required by therapists to develop clinical practice and achieve better outcomes for clients. This suggests therapists need to become more mindful about the intricacies of their practice (through research) and they need to reflect

upon the processes involved in their relational interactions with clients. In turn, by gaining more knowledge and demonstrating this knowledge to clients in the process of client progress, therapists can then meet the expectations of clients and work alongside them in managing positive and negative reactions by clients, and vice versa. This should help ensure clients feel less inhibited in expressing their therapeutic needs and more empowered towards achieving their goals.

1.7 Therapist Characteristics and Relational Factors in the Therapeutic Alliance

In the field of psychotherapy another dimension to therapists' contributions to TA and outcomes of therapy includes their characteristics. Ackerman and Hilsenroth (2003) suggest outcomes may have less to do with who therapists are and more to do with how they relate to their clients (Cooper, 2008). This has led to more attention in literature on the effect of therapist characteristics on relational factors which may attribute to a positive TA and how much 'the relationship' is valued by clients.

Ackerman and Hilsenroth (2001) who comprehensively reviewed the literature on therapists' variables, investigated characteristics that have a negative impact on the TA such as the therapist being rigid, critical, or distracted, etc. Conversely, Ackerman and Hilsenroth (2003) suggest warmth, flexibility, and being able to accurately interpret the client's distress can strengthen the TA. Ackerman and Hilsenroth (2003) believe more research is needed on the therapist's contributions to the TA. The importance of an affective bond and the therapist's ability to show empathy, acceptance, trust, and understanding are also valued by clients (Krause et al., 2011). Further, Dozier and Tyrrel (1998) who discussed transference and counter-transference as part of the dynamics in therapy, report client attachment styles based on previous relationships can affect the TA, that is, clients who feel secure with their therapists seem to have a stronger TA.

While clients' perspectives of the TA show them to be highly valued (Castonguay, Constantino &, Holtforth, 2006) and clients are strong determinants as predictors of good outcomes (Cooper, 2008), therapists are clearly important in the process of client

improvement as shown by Castonguay, Constantino &, Holtforth, 2006) Wampold, 2001). Claims on the important contributions therapists bring to therapy were discussed earlier by Baldwin et al. (2007).

Client improvement has also been acknowledged by Okiishi, Lambert, Nielsen, and Ogles (2003) and Okiishi, Lambert, Eggett, Nielsen, Dayton and Vermeersch, 2006). For example, Okiishi et al. (2003) found that in a group of therapists the most competent three therapists reduced symptoms significantly and reliably and contrasted with the performance of the least effective three therapists, whose clients failed to improve in therapy. However, it should be noted that in this study the sample is considered small with an average ratio of 14 clients per therapist. Okiishi et al. (2006) who looked to improve care at a university centre, by assessing for therapists' effects on the efficiency of treatment, included data from over 5000 client outcome scores seen by 71 therapists. In this study the authors found a significant amount of variation amongst clients' rates on client improvement.

The important contribution of the Okiishi et al. (2003, 2006) studies, was that findings were based on naturalistic rather than clinical trial research. In the latter, there is more opportunity to control therapists' effects under experimental conditions. A second important point is that in improving quality care, reflection on the outcomes of client improvement like those in naturalistic studies can help enhance therapists' performance on improvement because results will be more concerned with therapists' effects rather than controlling them. As this type of study can prove more relevant in real time therapy, they are indeed of value to psychotherapy literature. However, it should be acknowledged, that samples in both studies were once again (like others) drawn from university students in counselling centres in different countries with different cultures to that of the UK, and the samples were assessed as having mild to moderate diagnoses. While providing useful information on which type of variables in therapists might account for some generalities on quality improvement (such as common factor variables, e.g., level of therapist experience, chosen orientation) that can attribute to a positive or negative TA and outcome, in measuring therapist effects, this needs to be considered for a more diverse sample across the population, including using more severe presentations.

Heinonen, Lindfors, Härkänen, Virtala, Jääskeläinen and Knekt (2013) investigated therapist characteristics as predictors of formulation and development of client-related and therapist-related therapeutic alliances in short-term (ST) and long-term (LT) therapies. In this study, Heinonen et al. (2013) found the effects of confidence and enjoyment of work rated by therapists were similar to an earlier study (Heinonen, Lindfors, Laaksonen, & Knekt, 2012), which also identified links to therapists' characteristics on outcomes. In both these studies, authors acknowledge the importance of interpersonal basic relational skills (BRS), also found in Ackerman and Hilsenroth (2003) and Krause et al. (2011). The results highlight the influence of therapists' BRS in predicting the TA (whether in ST or LT therapy) and that a lack of BRS can be detrimental to the TA. For example, Heinonen et al. (2013), posit that BRS include: a composed, responsive personal presence, capability to be empathic, and to be able to communicate authentic concern over other people, or in other words, 'have a natural talent'.

As a point of interest for the common or non-common factor debate (DeRubeis et al., 2005), Heinonen et al. (2013) found 'advanced relational skills' (ARS), those acquired through training and ongoing practice, can sometimes be harmful to the TA. The authors claim that negative reactions by the therapist can occur, if their efforts are blocked in applying the more technical skills required in therapy. They suggest a reason for this could be because the client may not be ready or motivated to engage in the technical aspects of therapy as a result of their deep distress.

Overall whether in ST or LT therapies, the ability to relate at a basic level with clients seems integral to developing the TA. Thus, Heinonen et al. (2013) acknowledge, that the identification of interpersonal skills is a factor in the selection process of trainees. However, Crits-Christoph et al (2011) conducted a 'generalisibility theory' on analysis of the TA (a theory which addresses the adequacy with which one can generalise from a sample of observations to a universe of observations from which the sample was randomly drawn). In their study, the authors propose, that for trainees to be adequately evaluated on their ability to build a positive TA, a relatively large number of clients would be needed for each trainee. Crits-Christoph et al. (2011) simultaneously acknowledge that even if therapists experience low confidence in therapy which could

potentially affect the TA, awareness and close monitoring of interpersonal skills and techniques that could possibly result in ruptures in the TA can be supported in training and supervision to achieve good outcomes (Heinonen et al., 2013).

Muran and Barber (2010) propose greater emphasis on variables that could strengthen or weaken relational features of the TA. For example, they claim the TA itself could be used as discussion points between the therapist and client in therapy such as client's and therapist's different experiences, life histories, personalities, interpersonal or attachment styles, different ways of organising experience, expectations, and orientations to life. While it is acknowledged by Muran and Barber (2010) that such differences may have some negative influences in therapy, they also believe this could help with the development of treatment and improve process. As Lambert (2010) posits, learning about other perspectives on life values can be important, as well as overcoming ruptures in the relationship.

Noted at various points in this review, clients put a lot of value on their therapists (Krause et al., 2011). Bachelor (2013) also postulates that clients value help from their therapists as a factor in building the TA, and therapists seem dedicated to helping clients. However, therapists need to explicitly address how their particular strategies or interventions can be of help. In addition, therapists need to gain regular feedback from clients to determine goals and tasks and to avoid tensions. Exploring what is needed should also take place through mutual agreement (Bachelor, 2013).

1.8 Evolution of the Therapeutic Alliance

Over the years and particularly the last four decades, the review has shown that psychotherapy research shifted from earlier accounts which focused more on outcomes to 'within therapy' elements of therapy and relational processes between client and therapist such as in the Vanderbilt Project (Ardito & Rabellino, 2011). For example, the position of the TA has changed from de-emphasising the technical aspects, such as what is being done in therapy like task interventions and agreed upon goals, to emphasising relational features between the client and therapist (Safran & Muran, 2006), and yet back again, it seems. For example, in more recent years, developed from the Behavioural Paradigm (Robertson, 2010) there has been a surge on behavioural skills in

therapy to help alter maladaptive thoughts and behaviours in the form of cognitive behavioural therapy (CBT) (Beck, 1976, 1993).

CBT is an evidence-based therapy, achieved through randomised control trials (RCTs) reflecting the scientific inquiry applied in the medical model (Blair, 2010). Subsequently, the CBT model was enveloped into the National Health Service (NHS) Improving Access to Psychological Therapies (IAPT) service across the United Kingdom (UK). This service has been helpful for many people, but through its technical activity has medicalised therapy and has subsequently reduced the value of the therapeutic relationship (Rizq, 2013). The main assumption of CBT is based upon the premise: if we change the way we think, we can change the way we feel (Corey, 2005).

To help facilitate change in CBT, the therapist tends to follow an evidence based prescriptive treatment plan. CBT therefore requires the therapist to be more directive in therapy rather than collaborative, as a means towards achieving a good outcome, especially with those who experience specific psychological disorders. This could be one explanation why Waller, Evans and Stringer (2012), who examined the strength of the TA in the early stages of CBT on 42 females and two males with an eating disorder, concluded in their study, there is less emphasis on the TA in this model. They claim successful change helps the TA rather than vice versa. This suggests in the CBT approach, tasks or technical activity may predominate over the TA because this approach requires more emphasis on therapists' skills to elicit change, for example, in the case of eating disorders, as well as post traumatic stress disorder (PTSD) and obsessive compulsive disorder {OCD} (DeRubeis et al., 2005). In the person-centred and psychodynamic approaches, the therapist focuses more on the TA to facilitate change because collaboration and the interpersonal relationship are deemed central to achieving a good outcome. Whether there will once again be some radical turnaround in trends on what is best in therapy (technique or relational elements) remains to be seen. In the meantime, the evidence in this review has shown what is more important in the course of our practice is not what approach is used, but how therapists use their abilities and skills in meeting client needs at all points of the process.

1.9 Do We Need the Therapeutic Alliance and Therapeutic Alliance Measurement?

Despite the enormous attention given to the TA in literature that extends way beyond the scope of this study, Safran and Muran (2006) discussed the usefulness of the TA as a concept in therapy. They considered whether there is value in developing new TA measurement scales or refining the construct either through conceptual or empirical means. Concluding their discussion, Safran and Muran (2006) recommend greater emphasis on intersubjectivity (Stevens, 2002) is needed to develop authentic relatedness for those who believe the therapeutic relationship is central to the process. Moreover, Safran and Muran (2006) postulate that because the TA has been given a central role in the discourse among psychotherapy researchers, it will continue to do so. In summing up their discussion on a deconstruction of the TA, Krause et al (2011), advocate that the TA is very much alive.

TA measurement has been shown to be predictive of outcomes (Reese, Norsworthy, & Rowlands, 2009). But therapists can resist the use of TA measurement scales in therapy for various reasons. For example, Streatfield (2012), who wrote an article on 'the resistance to outcome measurement use, by therapists', suggested some therapists think measures get in the way of the therapy process and others view them as a threat creating anxieties on performance. As a case in point, these issues could similarly apply to TA measurement.

1.10 Summary of the Literature Review

This review aims to provide the reader with an understanding of the TA, its origins in psychotherapy literature and current standing and usefulness as a future construct in supporting the TA process and measurement in psychotherapeutic practice. The review discusses how the TA is currently measured, by whom it is rated, and ways in which therapists and clients might view the TA that may appear inconsistent. However, samples used in the reviewed studies that emphasise inconsistencies between clients and therapists, need more investigation using larger and more diverse samples that also need to be more gender-balanced, to be able to truly evaluate differences.

To help familiarise the reader with the type of components used in TA measurement, several interpretations on the factor structure of the TA in psychotherapeutic literature are documented to support future understanding (Bordin, 1979, 1994; Elvins & Green, 2008; Gaston, 1990; Hougard, 1994; Luborsky (1976) cited in Hovarth and Luborsky (1993) which favour similar and different constructs of what and how the TA is developed and maintained, but with no confirmed definition.

A thread throughout the TA literature shows that both relational features and technical tasks appear to be the main focuses for TA interventions, albeit to a greater or lesser extent, according to the standpoint of the author. These standpoints may be influenced by their chosen orientation and model on practice.

It was noted by the researcher, at the beginning of the review; that Freud (1913) emphasised a collaborative relationship in therapy, yet simultaneously acknowledged that the client's distress may mean that the therapist will sometimes need to steer the client back on track. Also noted was that clients clearly value the support of therapists (Bachelor, 2013). Freud's account and others in the literature tell us that at times of vulnerability clients may rely on therapists more than we currently appreciate. This suggests that despite much emphasis on a collaborative working therapeutic relationship, and the importance of clients' perspectives on the TA, we need to be ever mindful that therapists are the professionals who initiate and guide the process, albeit through agreement with clients.

Bordin's definition of the TA appears popular and accepted in literature (Ardito & Rabellino, 2011). This indicates we are seeing something in Bordin's model that resonates with many in the field of psychology and psychotherapy. That said, with many uncertainties on the TA, still, there may now be a greater need for a TA model which draws more predominantly on 'Basic Relational Skills' (Heinonen et al., 2013), thus a relational rather than theoretical TA construct.

Reference in the review has also been given to growing accountability on the part of therapists to ensure good practice prevails. This increasing development calls for evidence that is accurate to support these claims (Streatfield, 2012). The common factor

approach may therefore still be a way forward for future TA inquiry and benchmarking the TA. After all, if therapists and researchers can agree on the fundamentals on the TA and what is involved, clients will surely benefit.

As we further consider TA usefulness, the TA concept may (for some) seem something spiritual. That is, the TA is an entity in therapy that cannot be touched in a concrete sense. If a therapist chooses to believe in the TA potential, it can guide the therapist and client along in their journey. Alternatively, if a therapist chooses not to believe in the TA, that is their choice too. As Safran and Muran (2006) report, the TA is one of the most popular topics in psychotherapy research, yet different opinions on factors that make up the TA and emphasis on common factors are probably reasons why we have yet to determine its specific construct. Either way, in therapy, whichever standpoint one decides to reside, the way forward will always be an interesting and unique experience with every client. On that we can all depend.

1.2.1 Rationale for the Study

Research has yet to decide on a precise definition of the TA as the best predictor of outcome as well as the emphasis now put on a positive TA in therapeutic practice. In theory, the agreement does tend to lean towards a collaborative working alliance on tasks and goals and the relational bond (Bordin, 1979; 1994). However, due to a lack of understanding on the components of the TA, to what extent agreement is a mutual process in practice, or whether this is just clients' cooperating with their therapists, seems yet to be determined. For this reason, and others, the researcher of this study does not disfavour the continued need for client research on the TA. But at this moment in time, without a clear definition of the TA and different opinions having been formed, findings drawn from the empirical evidence on the impact therapists can have on the TA (albeit moderate effects) and the current demands on therapists producing clear evidence on quality and effective practice, each and all undoubtedly figure predominantly in protecting clients as well as in the process of sustaining services due to increasing limitations on funding. This means therapists need to build upon their existing knowledge to improve quality care, at the same time, or in other research, clients can then help enhance their own care through service-user inclusion policies developed in the UK.

The need for more evidence through the routine monitoring of outcomes in therapy tends to reflect the demands therapists working in public services now confront on a day-to-day basis. In the future, therapists' performance could also be judged on routine measurement outcomes (already underway in some countries and UK therapeutic services). As a case in point, studies are already emerging which highlight the pros and cons (Unsworth, Cowie & Green, 2012). These cultural changes and other subsequent factors are major reasons to now explore therapists' views on the TA more closely, so that they are better prepared for these challenges in helping clients.

For a considerable time, psychotherapy research has devoted substantial resources developing and testing therapies which emphasise interventions over the interventionist. This means less focus on therapists themselves (Luts, Leon, Martinovich, Lyons & Styles, 2007). This suggests:

> psychotherapy researchers typically focus exclusively on different clinical interventions while ignoring the psychotherapists who make use of them. It's as if treatment methods were like pills, in no way affected by the person administering them. Too often, researchers regard the skills, personality, and experience of the therapist as side issues, features to control to ensure that different treatment groups receive comparable interventions (Lebow, 2006, pp. 131–132).

However, it is important to also acknowledge that clinical trials are important, especially for gaining credibility on treatments as part of the commissioning of services. Nonetheless, as Blow and Distelberg (2006) claim, psychotherapy falls on the therapist to connect the dots in terms of how change occurs within specific treatment models, with specific clients, and with specific presenting problems.

Another reason to undertake this study is that therapists' and clients' perspectives on the TA have shown that clients value the help they get from therapists (Ackerman & and Hilsenroth, 2003; Bachelor, 2013; Bachelor & Horvath, 1999; Bachelor & Salamé, 2000), but therapist views have shown some tentative differences and similarities (noted earlier) on how the TA is perceived by both participants and this indeed needs further investigation. The TA studies on rating the TA have shown limited samples that include inexperienced therapists, replication of studies, which have at times used similar

samples, and other methodology issues have also been found. For example, Bachelor & Salamé's, (2000) and Bachelor's (2013) studies resulted in inconsistencies due to the amount of assessments completed in the studies, and the timing of the TA measurement by both therapists and clients through various unavoidable delays. In practice, this could easily result in different perceptions occurring with the TA because the client will naturally have different experiences to those of their therapist at different times within the process, according to what is taking place at that given time. As the results are inconclusive, this means more research is required. One example, could be based on interactions between the two parties, because there may be some aspects of the TA, such as what therapists need to have in their minds as they try to foster it, that are not directly accessible to clients? A further reason for focusing on therapists' views of the TA is due to cultural changes in health and social care systems which have given clients a greater voice in decision-making on their own care. This development has arisen because knowledge is now democratically available to clients, such as through the media and Internet technology, as opposed to previously relying on professionals (Elvins & Green, 2008).

According to Elvins and Green (2008), these secular shifts in healthcare systems means what takes place in therapy is bound to have an effect on what the TA is and how it is measured. For example, commissioning procedures in the UK on funding mental health services, as discussed in an article by Newbigging and Heginbotham (2010), along with increased accountability in measuring the effectiveness of the NHS as described by Streatfield (2012). Further the potential pressures and demands on therapists was reflected in a recent article which focused on client-rated measures of the TA being used to make judgements about a therapist's tendency to build a TA (Imel, Hubbard, Rutter, & Simon, 2013).

If such developments as those stated above continue to guide service provisions, this could not only mean TA measurement scales could increasingly become viewed as an essential commodity in measuring the quality of the therapy, alongside outcome measurement, and where financial constraints exist, but TA measurement could also be of influence in the management of a therapist's performance. The need for therapists to be better-informed and equipped to understand the complexities afoot in the TA process

from their own perspective as well as drawing on their knowledge of clients' perspectives, will undoubtedly become more important over time. For a case in point, when justifying good practice, Cooper (2008) implies it is becoming less acceptable for therapists to rely on subjective thoughts and feelings only, on the grounds that, "I know that what I do works" (p.8), inferring evidence is now crucial to how therapy works.

"The alliance concept has remained essentially at a descriptive level with little rigorous fundamental research as yet into the underlying process behind its formation" (Elvins & Green, 2008, p.1184). This suggests therapists have a responsibility to not only consider the common factors already described that seem to support the TA, but equally they need to explore in greater depth specific factors that help develop and maintain the TA at both an explicit and implicit level.

A further point of reference in support of an investigation on the TA from a therapist's perspective has been highlighted in a study undertaken on TA training practices (Constantino, Morrison, Nicholas, MacEwan, Gregory, Boswell, & James, 2013). In this study, the authors report limited literature exists on best practices for TA-focused training. This qualitative study explored the perspectives of 10 psychotherapy TA researchers on current and ideal TA-centred training approaches. The data derived from interview transcripts of the proceedings of two semi-structured discussions at professional conferences. Results indicated that most participants viewed current TA training as unstructured, while also expressing an interest in developing a more structured, gold standard approach. Participants also highlighted the psychotherapist's role in TA development and the importance of therapists' personal improvement strategies.

While these authors acknowledge the collaborative nature of the TA between client and therapist, it is clear, they (like others) and for reasons given here, also emphasise the importance of the therapist's role in TA development, findings consistent with those identified by Ackerman and Hilsenroth (2003). This means for over a decade or longer, it is clear researchers continue to support the value of therapists and the notion that more therapist research on therapists themselves is needed on the TA, as indicated at several points in the literature review.

The researcher believes that the many studies and views on the TA reported in the literature review, offer much scope in supporting past, current, and future thinking on the TA concept and in the process of understanding the complexities involved in the TA, upon which this study has certainly developed. However, to date, previous approaches had yet to reach clarity on the TA, and an agreement that could benchmark its components in the name of evidence-based practice. For this reason, it makes sense to approach the TA concept in an alternative way (from the perspective of therapists) because views are clearly underrepresented at such a political time within therapeutic services. Therefore, it is envisaged that this research would have the potential to enrich current knowledge as the views were drawn naturalistically from the experiences of those at the frontline of delivering therapeutic services. A focus in this direction will provide a unique opportunity for professionals, clients and the public, to immerse themselves into the unknown world of the types of scenarios that really happen in therapy, and how beliefs in the therapeutic process are conducted ethically as best practice.

Finally, therapists needed to know more about the TA, trainees needed to know more about what experienced therapists think about the TA and, as professionals, we continue to have a public duty to open up our investigations to inform clients and potential clients what they can expect at times of vulnerability having considered our approach in therapy from multiple perspectives. By focusing on therapists' (psychotherapists') views on the TA and identifying a factor structure that underpins the TA in how it can be developed, maintained and measured within one-to-one therapy, this has resulted in an investigation being conducted from the specific perspective of therapists. It is hoped that this approach will help to fill some of the gaps in TA literature which seem to have arisen from a lack of attention in this direction. This research therefore endorses the ongoing work of therapists, by encouraging them to be reflective and reflexive practitioners in both practice and research. Therapists hold professional responsibilities for clients in the course of the therapeutic process and particularly, as they confront the cultural changes afoot, regarding accountability on practice. Therefore the platform was set, on which therapists from many different theoretical directions stood to explore and share beliefs on the TA, a position that will surely represent the best interests of clients.

That said, research on the views of therapists can be part of a larger body of research, but which may be limited in not taking into account the views of their clients.

1.2.2 Relevance to Counselling Psychology

Counselling Psychology collaboratively explores implicit issues that may unknowingly cause a client distress and can be effective in the process of empowerment as the client is helped to confront change (Sims, 2010). Counselling psychology suggests a process of learning through a humanistic value-base with a relationship built on mutual respect, trust, and equality to achieve personal growth within the relationship framework. These qualities are characterised by Rogers (1951) in the person-centred model as empathy, acceptance, and congruence (Strawbridge & Woolfe, 2003). Counselling Psychology posits a high level of personal awareness on the part of the therapist to ensure clients are protected from harm when in the therapeutic process and through the many aspects of ethical practice (BPS, 2009; Shillito-Clarke, 2010)

As this study calls for much reflexivity on the participant's part, the concept of 'introspection' described by Burnard (2002) as "inward focusing of attention" (p.34) is useful for therapists' to support self-awareness in therapy to protect clients. This concept reflects ethical principles of counselling psychology detailed by Shillito-Clarke (2010).

From a multi-therapeutic perspective, to date there is extensively written literature on many facets of the therapeutic process as well as discourse and dialogues in how to undertake practice. However, there is no specific therapist reflective self-assessment clinical TA therapist tool that could quickly and simply inform trainees and therapists regarding the key elements of the TA which could demonstrate ongoing ethical practice. Neither is there a simplified guide, which would effectively allow the trainee or therapist to sequentially manoeuvre through the processes of therapy, allowing for self-reflection and personal reflexivity.

This type of therapist awareness tool envisioned by the researcher through its construction in this study could therefore be of benefit in several ways, for example,

- to facilitate learning in the training environment pre-practice,
- to endorse more structure in practice,
- to be utilised in supervision, as a means to assist trainee and supervisor or therapist and supervisor to reflect the therapist's approach in developing and maintaining the TA,
- to support benchmarking and evidence-based practice following further construction and testing.

In short, this type of tool would enable therapists to endorse what Mearns and Cooper, (2009) describe as: 'work at relational depth', because reflective activity is a key component to good practice (Strawbridge & Woolfe, (2010).

This study supports the core elements of Counselling Psychology practice because: (a) clients are central to the research investigation through therapists understanding of the TA, (b) the research will remain flexible in exploring new dimensions on the TA concept attributable to psychological literature and practice, and (c) the study will encompass different therapeutic styles that could collectively provide a yardstick in achieving good clinical outcomes in therapy.

To this end, this study will allow for training providers and trainees, qualified therapists and clinical supervisors, who each reflect therapeutic skills in the development of competent practitioners, to help ensure the field of psychology, psychotherapy, and counselling continues to flourish and that clients' needs remain fully incorporated in the process.

1.2.3 Ethical Considerations

This study was given full ethical approval by the School of Arts & School of Social Sciences Research Ethics Committee, City University London. From the outset, the researcher was mindful that any participant involved in psychological research could be subject to a degree of harm when providing personal psychological data which can make some feel vulnerable. The researcher's intention was to work ethically at all stages of the research process in line with the BPS (2009) ethical code to minimise harm. Debriefing Information, Retrieval of Data, and the How to Obtain Research Findings Form, were all issued to participants as part of their research package to inform them of their rights within the research process. This included whether more support was needed in addition to that offered by the researcher. For participants who were involved with

the online survey, compliance with 'Guidelines for ethical practice in psychological research online'(BPS, 2007) as well as 'British Association of Counselling and Psychotherapy (BACP) Ethical guidelines for researching counselling and psychotherapy (Bond, 2004) steered the process.

The researcher also adhered to the four main ethical principles of respect, competence, responsibility, and integrity in relation to the BPS (2009) and this remained consistent at each stage of the research process. This included respect for autonomy, making provisions for participants to be their own decision-makers, in terms of consent, participation, and withdrawal. In addition, as a counselling psychologist, the researcher at all times ensured:

- *'beneficence'* was demonstrated which promotes the best interest of participants;
- *'non-maleficence'* was maintained making sure no harm is done to participants;
- *'justice and fidelity'* was upheld in terms of fairness and equality towards each participant (Shillito-Clarke, 2003).

Consent forms and demographic information were held by the researcher only and stored separately from other data, such as transcripts, to protect anonymity and to maintain confidentiality. A coded system for data helped maintain confidentiality (see procedure section for details).

1.2.4 Reflexivity

Pidgeon and Henwood (1997) propose that reflexivity allows the researcher's subjectivities to be brought into public light and tells a more comprehensive account than that found in scientific report writing, thus moving towards strong objectivity. Willig (2001) proposes different types of reflexivity, 'personal reflexivity' and 'epistemological reflexivity' and acknowledges that researchers will differ in how much emphasis they put on reflexivity.

According to Willig (2001) a qualitative researcher tends to put reflexivity central to the research process, while others might tend towards a less in-depth discussion. Personal

reflexivity focuses on the researcher's own principles, values, beliefs, and wider interests such as social and political commitments that help shape the research. Epistemological reflexivity encourages us to draw upon 'knowledge', and how the design of the research and specific method used contributes to our findings or that may have resulted differently if other elements or methods were employed. However, personal reflexivity and epistemological reflexivity are linked processes, but the latter involves more of an examination on techniques of sense-making (Cushway, 2009). Kasket (2012) proposes 'methodological reflexivity' described as the choices made within the research itself, how decisions help shape the results, and issues that arose, and how each was managed.

The researcher sees personal and epistemological reflexivity as standpoints in the research on what the researcher proposes to do and why. Both types of reflexivity are discussed in the following two sections. Methodological reflexivity will be reviewed at the end of the study because this will explain what resulted from what was done and why.

1.2.5 Personal Reflexivity

In this study, the researcher has taken the standpoint of not only being researcher, but one of observer and shared-learner. This means throughout the research process, the researcher will have a personal and vested interest in how this study unfolds and how knowledge on the TA transpires to support the researcher's own practice. However the researcher will remain aware of possible subjectivity on the research topic and attachment to the research (Willig, 2001).

As evidenced in the literature review, there is greater demand for evidence-based practice across psychological service, so it is important for therapists to ensure the elements that constitute ethical practice and accurate measurement of practice are continually reflected upon. Simultaneously, it is important to ensure the contributions of therapists remain valued in therapy because (as also evidenced) cultural changes are occurring in therapeutic services calling for increased accountability and evidence-based practice to clarify the quality of therapy as well as the funding of services. This could mean that therapists become more task-assessment driven rather than relationship

driven, despite the current evidence that shows the latter to have better effects on outcomes.

The researcher's position as 'shared learner' is due to her current practice as an applied psychologist and clinical supervisor. The researcher desires more knowledge on the TA that will enable offering the best opportunities in facilitating the growth of clients. This is achievable with greater understanding of the processes involved in human interactions and how certain techniques may support these interactions. In striving for this position, it is hoped vulnerable clients can be empowered to actualise their potential (Kasket, 2012). A further incentive in undertaking this study is the need to remain professionally ahead and informed on any new knowledge that can reliably inform supervisees on the protocols of good practice in achieving successful outcomes. Moreover, the researcher envisions that (through the results of this study) the experiences will help, through a deeper appreciation of skills and techniques identified, favourable to the concept of the TA. Sharing research experiences should enable supervisees to self-explore their own style in the development of professional practice on meeting the required high standards.

Although the researcher is an integrative practitioner, she needs to be mindful that there will be different theoretical orientations invited as welcomed guests to the research table. This means an appreciation and readiness that different preferences from that of the researcher's own will be inevitable and need to be accommodated. As different viewpoints converge on the TA, this will surely add richness and rigour to the research.

To prevent possible biases on different perspectives that could present on the researcher's part, during interactions with participants, whether through personal contact in the focus group, with panel judges, or through e mail with online participants, the researcher will be mindful of the effects of interactions and interpretations of responses in order to support good ethics in the research process.

In writing up the findings, the researcher will aim to offer a fair and just account that explains and respects views through evidence in literature, both empirically and theoretically. The researcher's personal position in this research will therefore be

accepting and non-judgemental in respecting the uniqueness of individual contributions and reflecting principles and values of those adopted with clients and supervisees.

1.2.6 Epistemological Reflexivity

When considering the epistemological position on this study, Willig (2001) suggests that the researcher needs to be clear about research objectives. Moreover, the researcher needs to use research methods that will guide them to their goal, and thus adopt an epistemological position that is realistic regarding what is under investigation and how one aims to find this out.

In undertaking a qualitative and quantitative methodology, the researcher's epistemological position leans somewhat towards 'empiricist' because this position "is based on the assumption that our knowledge of the world must be derived from the facts of experience" (Willig, 2001, p.10). For example, Willig (2001) posits in the case of qualitative content analysis (the qualitative analysis applied in this study) the empiricist position would mean that through the transcript (in this study generated from the focus group) the text is seen as a straightforward verbal expression of the participants' mental processes. The researcher has also employed a statistical design to account for objectivity on the TA as an evolving phenomenon.

This means the research will be approached inductively on the experiences or factual accounts of participants, but will draw upon deductive reasoning and theoretical formulation of the TA as described by Bordin (1979) and others. In this research the epistemological position is one of empiricist and theorist, as both positions reflect the construction of new knowledge, yet with the understanding that their differences lay in the 'raw material' rather than their knowledge construction processes (Mauthner & Doucet, 2003).

The researcher also decided to adopt a 'pluralistic' attitude because this standpoint reflects the role of counselling psychologist and counselling psychologist researcher which "means being open to exploring all the paradoxes, divergences, and different perspectives we may encounter in the literature reviewing process and beyond" (Kasket, 2012, p.66). Kasket (2012) claims this standpoint leads towards creativity and new

knowledge and is one that allows for openness and less rigidity as well as a 'non-hierarchical' relationship with participants. An open mind in research helps the researcher remain guided and informed by ethical processes and standards (BPS, 2009).

The current study does not marginalise any population within the context of TA practice or any psychological difficulty. Thus, it is hoped readers will deliberate the findings here and in other TA studies on young, adult, or older clients, and adopt practices that best reflect their particular client therapeutic environment.

1.3.1 Research Aims

The first aim of this study was to explore therapists' views on the therapeutic alliance in developing best practice. A second aim was to determine whether a new therapeutic alliance measure could assist therapists in training, practice and clinical supervision.

1.3.2 Research Objectives

The objectives of this study were to:

- Produce a new therapeutic alliance measure that could support best practice
- Identify the most sufficient factor structure underpinning a new measure of the therapeutic alliance
- Explain the theoretical model of therapeutic alliance development and maintenance as viewed by therapists.

1.3.3 Research Questions

1. What are the perceived components and factor structure in therapeutic alliance measurement?
2. What does a sample of therapists think about the potential for a new measure to assist them in awareness of the therapeutic alliance?

1.3.4 Pilot Study

Prior to the commencement of the main study, a pilot study was undertaken through friends of the researcher to gain a feel for how TA measurement in therapy from both a

therapist and client perspective might be conceived. Six people over 18 years of age participated in a role-play scenario, to initially identify reactions to being asked to score their opinions on a recently developed TA measure. Participants were first asked for views as clients and then as therapists. The Sessional Rating Scale (Miller & Duncan, 2000) was used to prompt discussion because it is a very brief measure with only four items. The pilot study helped the researcher consider some of the advantages and disadvantages of being presented with a TA measure as a client or presenting one as a therapist in the context of therapy.

Albeit hypothetical, when acting as clients, some thought it would help them give more consideration regarding what had taken place in the session, whereas others felt they might not be honest if completing the measure in front of the therapist at the end of the session. When acting as therapists, in principle, therapists could see the advantage of monitoring the TA, but others still thought clients may not be honest when asked to fill in the TA measure in front of a therapist, moreover, despite having been informed that in reality therapists would offer reassurance to the client that their honesty was important. A further comment was made as a therapist regarding being monitored, although at the beginning of the pilot study all were informed by the researcher this is not the purpose of TA measurement.

Chapter 2: Methodology

2.1 Research Design

The research comprised three phases of data collection: Phase three was undertaken in two parts, A and B.

2.1.2 Phase One - Overview: Focus Group

Phase one of the research was qualitative in nature, and consisted of a Focus Group where participants were asked to explore views on the TA based on current knowledge, experiences, and literature to help identify factors that could generate statements for the new TA measurement scale. Two widely used and rigorously tested TA scales were

used as prompts for the focus group exploratory investigation. Data collection was audiotaped following consent.

2.1.3 Phase Two - Overview: Panel Judges

Phase two involved the construction of a new TA measurement scale, employing a hybrid (mixed) Thurstone-Likert methodology as proposed by Oppenheim (1992). The items for the new measurement scale were developed initially from statement items generated from focus group data. A panel of judges (different research participants) were invited to test the strength of the items that were evaluated on a one to 11-point rating scale. A semi-interquartile range methodology was applied to measure variability on items from participant responses and in the selecting of the final statements for the online survey.

2.1.4 Phase Three - Overview: Online survey

Phase three involved two parts. Part A involved setting up a web-link to Internet websites for therapist and trainee member access. Part B involved creating a measurement scale (a Likert-type scale), which was tested through an online survey. Exploratory factor analysis (EFA) (Fabrigar, Wegener, MacCallum & Strahan, 1999) was subsequently performed on survey responses.

2.2 Participants

A total of seven participants took part in the focus group Female: N = 7 Male: N = 0 (Table 1). Eleven participated as independent panel judges, Female: N = 6 Male: N = 5 (Table 2). One hundred and six responded to the online survey. Ninety-one completed all sections of the online survey and subsequently entered into the Statistical Package for the Social Sciences (SPSS) statistical analysis. Descriptive statistics on demographics for online survey participants are displayed in Table 4, Chapter Three: Results section.

Table 1: *Demographics: Participants –Focus Group*

Job title	**M/F**	**Age range**	**Current Qual.**	**Yrs. Qual.**	**T. /Orient.**	**Use TAM Every Session**	**Use TAM Begin/end Session**	**Use TAM Randomly**
Couns.	Female	41-50	Degree	1	Person-Centred	No	No	No
PsychoT	Female	51-60	MSc Degree	19	Human Givens	No	No	No
Couns.	Female	Not stated	Diploma	24	Mindfulness	No	No	No
PsychoT.	Female	51-60	Post Graduate Diploma	5	CBT	No	No	No
Couns.	Female	41-50	Degree	4	Person-Centred	No	No	No
PsychoT.	Female	31-40	Post Graduate Diploma	2	Pluralistic	No	Yes	No
Couns.	Female	51-60	Diploma	9	Person-Centred	No	Yes	No

Table 1: shows Job title, Psychol. = Psychologist, PsychoT. = Psychotherapist, Couns. = Counsellor, M/F = Gender, Age-range, Current Qual. = Current Qualification, Yrs. Qual. = Years Qualified, T. Orient. = Therapeutic Orientation, Use of TAM = Use of Therapeutic Alliance Measure. Total years post-qualified experience = 64 years.

Table 2: *Demographics: Participants –Panel Judges*

Job title	**M/F**	**Age range**	**Current Qual.**	**Yrs. Qual.**	**T. Orient.**	**Use TAM Every Session**	**Use TAM Begin / end Session**	**Use TAM Randomly**
Clinical Psychol.	Male	51-60	Doctorate	32	CBT	No	Yes	No
Clinical & Health Psychol.	Male	41-50	Doctorate	22	CBT	No	No	No
Clinical Psychol.	Female	31-40	Doctorate	7	Third wave CBT Systemic	No	No	Yes
Counselling Psychol.	Male	41-50	Doctorate	13	CBT	No	No	No
Counselling Psychol.	Female	41-50	Doctorate	10	Humanistic DBT	No	No	No
Clinical & Health Psychol.	Male	21-30	Doctorate	3	Person-Centred	No	Yes	Yes
Counselling. Psychol.	Male	41-50	Post MSc Diploma	13	DBT	No	No	No
Counselling Psychol.	Female	41-50	Post Graduate Diploma	10	Humanistic / Person Centred	Yes	Yes	No
Counselling Psychol.	Female	31-40	MSc Degree	4	CBT	No	No	Yes
Clinical Psychol.	Female	41-50	Doctorate	14	CBT	No	No	No
Couns.	Female	31-40	Post Graduate Diploma	8	CBT / Integrative	Yes	No	No

Table 2: Shows Job title, Psychol. = Psychologist, PsychoT. = Psychotherapist, Couns. = Counsellor, M/F = Gender, Age-range, Current Qual. = Current Qualification, Yrs. Qual. = Years Qualified, T. Orient. = Therapeutic Orientation, Use of TAM = Use of Therapeutic Alliance Measure. Total years post-qualification experience = 136 years.

2.2.1 Inclusion Criteria: Phase One and Two - Focus Group and Panel Judges

Participants in these two phases consented to take part either as a focus group member or as a panel judge, which involved the same inclusion criteria. Participants needed to be a qualified therapist over 18 years of age, have completed a minimum two-year Diploma therapeutic training programme, and be in current practice (public, voluntary, service, or private practice), which offers psychotherapeutic work on a one to one basis. Internet access was stated in the criteria (not compulsory if other means of contact were preferred) to enable the researcher to make contact regarding venue details or possible withdrawal, considered a benefit to participants for easy contact during the research process. As the study was undertaken in the UK, participants needed to speak English.

2.2.2 Exclusion Criteria: Phase One and Two - Focus Group and Panel Judges

The exclusion criteria for phase one and two of the study included those below 18 years of age and trainee therapists. Anyone below 18 years of age is highly unlikely to be working autonomously in psychotherapeutic practice on a one to one basis, as they would not yet have reached the academic level of training and practice to fit the inclusion criteria as practising therapists with a minimum two-year diploma. Trainees were excluded from phase one and two of the study because they would lack the clinical expertise of those post-qualification.

2.2.3 Inclusion Criteria: Phase Three - Online Survey

Participants needed to be over 18 years of age and had completed a two-year therapeutic training programme and in current practice, or enrolled on a therapeutic training programme as a trainee.

2.2.4 Exclusion Criteria: Phase Three - Online Survey

The online survey was not open to the public or anyone below 18 years of age.

2.2.5 Recruitment

The researcher offered a £50 Draw incentive for those who would take part in the focus group or as a panel judge. This gesture was in respect of the time involved for

participants as professional therapists to attend a research venue allowing for time and travel.

For the first two phases of the research, the focus group and panel judge participants were recruited through a recruitment poster courtesy of local counselling, psychology, and psychotherapy service providers including the NHS. As only NHS staff was needed for this study and not patients, full NHS ethical approval was not required. Written confirmation to approach NHS staff was given and obtained through appropriate channels from NHS Clinical Governance (see appendices).

Recruitment of participants for phase three of the research for the online survey, were contacted either courtesy of the British Psychological Society, British Association for Counselling and Psychotherapy and UK Counselling Directory research pages. Counselling and Psychotherapy services that displayed an e-mail contact address within England, Ireland, Scotland, and Wales were randomly contacted requesting voluntary participation.

2.2.6 Sample Size

Seven participants were recruited for the focus group and (although opinions vary), 6-12 seems to be a generally accepted number (Robson, 2011). Eleven participants represented a panel of judges to test the strength of the items most favourable to the concept of the TA. One hundred and six participated in the online survey resulting from the panel judges' analysis, but only 91 completed all 27 survey questions (items). There has been much written about sample size in general (Robson, 2011) and for factor analysis (Field, 2013; Hogarty, Hines, Kromrey, Ferron, & Mumford, 2005; Tabachnick & Fidell, 2007). Field (2013) posits that the more frequent and higher the loadings are on a factor, the smaller a sample can be to justify suitability in performing factor analysis.

2.2.7 Procedure

Research packs were distributed to participant line managers by the researcher approximately two weeks after permission was obtained to approach potential participants. These included four items: an information sheet, a participant's consent

form, a debriefing information sheet, and a pre-paid addressed envelope for return of consent forms to the researcher.

Participants were asked to consent to participate as either a focus group member or panel judge. They were not required to do both. There were two considerations regarding who would participate as either a focus group member or panel judge to help meet practicalities on the research data collection period.

1. Participants who returned their consent forms earlier were asked to attend the focus group, and using the same procedure, those participants who returned forms later were selected as panel judges.

2. Participants' availability was also considered with regards to who would participate as a focus group member or as a panel judge.

Consent to approach participants from the NHS was received later than other services, which meant NHS participants naturally responded later. However, the panel judges were not solely made up of NHS employees. These considerations helped meet the timescale of the study and the majority availability. Upon receipt of consent forms, the researcher contacted each participant by e-mail to provide details on an expected date for each data collection phase.

Focus group participants met at a conveniently located venue and were given verbal information by the researcher about the study. In this study, the researcher's role in the focus group was one of 'moderator/facilitator' and not as a participant. This meant the researcher was not part of the focus group discussion (data collection). Being a moderator/facilitator meant ensuring ethical issues on research were adhered to, and all procedures which involved data collection were managed appropriately. This involved:

- Making sure that prior to, and throughout the data collection period, clear explanations were given to participants on what was expected of them. This also included providing a verbal outline of the TA for both focus group members and panel judges (see appendices 13 and 18)

- Opportunities for questions were given so that each participant understood their role
- The duration of the data collection period was time-managed to concur with participant information and participants' willingness to take part in the study.

As moderator/facilitator, it was also important to ensure participants were treated fairly and respectfully as well as offering respect to one another. For example, as the data were being audiotaped, participants were given verbal instructions on maintaining the anonymity and confidentiality of respective focus group members. Participants were also asked to refrain from using any identifying information, such as names (if acquired on first meeting just prior to the data collection), or the name of colleagues or workplaces, etc.

Finally, prior to the actual recording, to ensure clarity prevailed in obtaining quality data, participants were asked to speak one at time and (in respect of the time available) were asked to show fairness to other participants in expressing views.

Following confirmation on clarity from each participant, focus group participants were then presented with two (therapist version) TA scales: The Working Alliance Inventory–Short, (WAI-S) (Tracey & Kokotovic, 1989) and The Helping Alliance Questionnaire II, (HAQ-II), (Luborsky et al., 1996). These TA scales were offered as prompts, but were optional and only intended to generate ideas in the focus group as an adjunct to their own professional views through therapeutic experience with a wide range of clients. The TA measurement scales are detailed in section 2.2.8 and rationale for the use of the two TA measures is provided in section 2.3.3.

Finally, to conclude the instructions for both focus group members and panel judges, debriefing information was reinforced verbally following the written information issued in the research pack. Demographic forms were completed prior to data collection. These forms were coded to elicit which participant attended which group, for example FG (focus group) 01 or PJ (panel judge) 02, etc.

There were approximately eight weeks between phase one and phase two data collection periods. This allowed for manual scrutiny of the transcript and computer analysis of the

data by the researcher, in generating 51 statements as part of the initial process in the construction of the new TA measure. When the initial statements were completed, the researcher contacted those who had agreed to participate as panel judges to reconfirm consent and attendance.

Prior to the data collection, panel judges were given verbal instructions on the data collection and provided with a summary of the TA (the same information as that offered to focus group members which included asking their assistance in completing a demographic form). Panel judges were then given precise instructions on their role in the research in terms of rating the statements (appendix 18). They were each asked to rate the 11-point scale items independently, a scale that reflected Thurstone's Equal-Appearing Intervals Scale (Elder, Wallace, & Harris, 1980). Participants were asked not to converse with other participants while scoring statements. Panel judges were also given an explanation on Thurstone's model and how to evaluate items from least favourable (TA scored as 1) to most favourable (TA scored as 11). To provide clarity on what was expected in this phase of the research where Thurstone describes 'objectivity' on responses, Oppenheim's (1992) perspective on 'objectivity' infers responses that required professional judgements rather than personal preferences yet, in essence, acknowledges both could well overlap. Therefore clarity was needed to support the methodology. This in mind, participants were offered the following example by the researcher, to help with their evaluations:

> "If you were a Judge in a Court of Law, and the person in front of you needed to be sentenced, you would be expected to decide a sentence that best fits the seriousness of the crime and in compliance with legal proceedings. For example, hypothetically, a person who stole something expensive from a shop might result in a two-year jail sentence. However, you might not personally agree with the sentence because of your own principles and values on the length of sentencing for certain crimes". (This example is also stated within the panel judges' data collection instructions in the appendices).

By acknowledgement from panel judges and no further questions, the above example (theme optional), confirmed to the researcher that participants understood the requirements of how to rate statements requiring their professional judgement rather personal preferences in how they would proceed. The rating of items lasted between 30 to 40 minutes.

Following the analysis of the statements (see the data analysis section in Table 3) the final 22 statements were selected as the new TA measurement scale. This number of items gave two statements per scale-value and was considered a reasonable number for a TA measure in comparison to widely used measurement scales and those that have needed to be reduced in size, for example, Tracey and Kokotovic (1989).

The 22 statements were included in an online five-point survey scale which were scored from Strongly Disagree = 1, Disagree = 2, Neutral = 3, Agree = 4, Strongly Agree = 5, to help answer 'Question One' of the research (What are the perceived components and factor structure in therapeutic alliance measurement?) A further five questions also formed part of the survey (formatted as above) to help answer research 'Question Two' (What does a sample of therapists think about the potential for a new measure to assist them in awareness of the therapeutic alliance?).

All 27 items were subsequently analysed through exploratory factor analysis. To help reduce any bias on the researcher's part on the use of TA measurement scales, three additional yes or no questions on TA measurement use were also introduced. To ensure ethical procedures were complied with for online research (BPS, 2007), a front page at the beginning of the survey explained the research, which included reference to anonymity, confidentiality, voluntary participation, and debriefing procedures. Participation in the survey meant voluntary consent was obtained. Demographic information reflecting that required by focus group and panel judge participants was also requested. The survey was open for 12 weeks and concluded the data collection for this study.

2.2.8 Materials

- **Demographic Form** compiled by the Researcher.
- **The Helping Alliance Questionnaire II.** The HAQ-II (Luborsky et, al., 1996) is a widely used 19-item paper and pencil questionnaire that measures the strength of the client/therapist alliance. Each item is rated on a six-point Likert scale (1 = 'I strongly feel it is not true' to 6 = 'I strongly feel it is true'); with negatively worded items are reversed scored. Cronbach's alpha = .90 for a sample of $N = 345$.
- **The Working Alliance Inventory–Short WAI-S** The WAI-S (Tracey & Kokotovic, 1989) is a widely used 12-item paper and pencil questionnaire that measurers the

strength of the client/therapist alliance. Each item is scored on a seven-point Likert scale (1 = never, and 7 = always), and assesses one general scale (General Alliance or Total) and three subscales. The WAI-S has strong internal consistency, ranging from .70 to .91 for the subscales and .90 to .97 total score for a sample of *N* = 62 (appendix 11 and 12).

2.3 Data Analysis

2.3.1 Analysis Overview

Manual analysis was first of all, performed on the focus group transcript applying Saldaña's (2009) model of 'In vivo' coding and then the computer analysis. Please note: 'qualitative content analysis' (QCA) performed in the computer analysis described below, was an adjunct to the manual analysis (undertaken separately) but both comprise the qualitative content analysis procedures for this study. In vivo coding is based on the respondent's own words and helps capture key elements of what is being described. QCA is defined as a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns. QCA provides knowledge and understanding of the phenomenon under study (Hsieh & Shannon, 2005). As this was an independent small study, all analysis procedures were performed by the researcher. Although the researcher did not contribute to the focus group discussion/data collection, to help obtain validity, it was decided that two separate types of QCA (manual and computer) would be performed on the transcript. The transcript from the audio-tape was transcribed verbatim into a word-processing document.

The manual analysis process involved the following steps:

1. Using a computer word-processing document split into two columns, the transcript was copied into the left hand column
2. The researcher then scrutinised the entire transcript, and then went back through it again, numbering and "...separating the text into short paragraph-length units with a line break in between them whenever the topic or subtopic appears to change" (Saldaña's (2009, p.29). Or as Saldaña realistically puts it, quoting Glesne (2006), do this as best as you can, because in real life, "...social interaction does not occur in neat isolated units"(p.150)
3. Interpretation of phrases, clusters of sentences and words (quotes) were made subjectively (as in the process of In vivo coding), yet, selection of data for potential TA scale items was done by also using professional judgement on practice, that is, a) quotes needed to directly address the TA as given by a respective participant, or b) where a participant gave reference to the components of the TA that best reflected the process of

> therapy in support of the interpersonal relationship as viewed in Bordin's (1979) popular model of goals, shared tasks and an attachment bond, c) any other quotes were selected if this identified any new important aspects of the TA that emerged in the focus group discussion that were deemed useful in better understanding and developing and maintaining the TA concept. Further analysis on the selection of data that would best represent items (panel judges) would be independently judged by different participants (least and most favourable to the TA concept) as a subsequent part of the overall data analyses in this study. Applying this protocol clearly demonstrates the steps taken in the manual analysis process, where each interpretation made by the researcher was then recorded in the right hand column alongside the respective transcribed text (see appendix 14).

Subsequently, the selection of quotes which helped generate the 51 initial TA measurement scale items (statements) and refining of items regarding clarity is further supported by considering methodology factors discussed by Loewenthal (2001) and Cheung and Renswold (2000) on pages 75-77 and pages 91-92 in finalising items for a measure (Trochim, 2006).

QCA was performed through NVivo 10 computer coding (QRS International 2012) also on the focus group transcript (phase one). To measure variability on responses, a semi-interquartile-range on the panel judges' scores was employed (phase two). Likert-type scale methodology was employed on the online survey (phase three). Exploratory factor analyses was performed on online survey responses using 'principal axis factoring' which is a default method of extraction used in statistical software packages, including SPSS (Field, 2013). Due to the small number of participants as focus group members and panel judges, demographics are displayed as raw data in table format. Descriptive statistics were performed for online survey participants using statistical analysis: SPSS version 21 (IBM SPSS Statistics, 2012).

The manual analysis (performed on the transcript) was the main data source in compiling the 51 original statements (appendix 19). Computer use in analysing qualitative data can increase effectiveness and efficiency in learning about data because it has the capacity to record, sort, match, and link data harnessed by the researcher. A computer also helps rigour in the analysis process (Bazeley & Jackson, 2013). In this context the computerised analysis of data was used to cross-validate the manual data and to explore new themes. Subsequently, the 51 items were sifted down to 22 items through further analysis (semi-interquartile range) on panel judges' responses to items (statements), which were finally considered to be most favourable to the TA concept in the construction of the new TA measure. Along with the survey responses on the 22

items, and EFA, collectively, all analysis procedures helped answer the two main research questions (section 1.3.3).

2.3.2 Phase One: Rationale for a Focus Group Interview

Focus groups are a form of group interview, but different in that the participants are encouraged to talk to one another rather than each being interviewed directly by the researcher. Thus focus groups are less rigid and less structured, enriching spontaneity among different participants in an interpersonal and intrapersonal way in social sciences research (Kitzinger, 1995).

A focus group seemed appropriate in phase one of the data collection because it helps generate ideas from group members who each had varying levels of therapeutic experiences from different training schools and with different clients across the lifespan. The focus group interview was audiotaped and transcribed verbatim.

2.3.3 Phase One: Rationale for Focus Group - Use of Two Measures

The HAQ-II (Luborsky et al., 1996) and WAI-S (Tracey & Kokotovic, 1989) TA measures which are detailed in section 2.2.8 were developed from Bordin's (1979) model. There were several reasons why the researcher decided to use these particular TA measures in this study. First of all, both are widely used measures and are regularly documented in TA literature due to their reliability and validity (Andrusyna et al., 2001). In addition, the HAQ-II and WAI-S are therapeutically integrative to help reduce bias amongst therapists' respective orientations (Martin et al., 2000). In the development of a new TA measure constructed in this study, the researcher was aware that psychological measures (e.g. IQ scales, attitude scales and the like) have followed similar procedures and have drawn on previous measures to provide a starting point as stimulus material. Focus groups require a focus and there is a long established tradition of using them to generate an initial set of statements when constructing new measures (Trochim, 2006). The idea being to concentrate discussion in a way that validly taps into people's experience of the topic. That is, to give participants (including those who may be less knowledgeable on the topic) an opportunity to elicit a degree of phenomenal representation, especially on a topic like the TA that is completely abstract and cannot be easily made concrete. Having concluded from the literature review that the two

measures appear to capture key elements of the TA, the researcher believed the measures would assist participants in identifying the intricacies of the TA at both an implicit and explicit level, moreover, at what points in the therapeutic process both types of interactions might emerge in achieving the TA. Thus these measures were used purely to help generate ideas in the process of raising participants (therapists) awareness on the TA, and from the new information gained, subsequently assist them in training, practice and clinical supervision. To this end, the two measures were intended to help clarify how therapists go about developing and maintaining the TA, rather than what it comprises – albeit to some, this may seem a subtle distinction, as a result of TA complexities (Green et al., 2013).

2.3.4 Phase One: Rationale for a Focus Group Manual Analysis

A code in qualitative inquiry is often a word or short phrase that symbolically captures the essence of a portion of language or visual-based data (Saldaña, 2009). Although coding can be time-consuming (Robson, 2011), manual analysis allows a researcher to identify dialogue that has similar meanings to the specific category to that analysed through the computer system and input theme (Welsh, 2002). Welsh, suggests that to maximise validity on qualitative analysis both techniques are used.

2.3 5 Phase One: Rationale for a Focus Group Computer Qualitative Content Analysis

Data from the focus group were analysed through the application of Qualitative Content Analysis (Mayring, 2000) and supported by a computerised programme using NVivo1O (QRS International, 2012). There are several reasons for using computer coding, such as a) speed and accuracy in obtaining data searches which add rigour to the process, b) ease in seeing data relevant to the theoretical ideas because they are systematically evidenced to show validity of the research results, and c) reduction of human error (Welsh, 2002). Qualitative Content Analysis also allows for a more qualitative interpretation and incorporates two approaches: ‘Deductive’ and ‘Inductive’ category development (Mayring, 2000).

- A Deductive approach helps generate variables from a theory such as (Bordin, 1979) the TA model and is especially useful at the beginning of qualitative data analysis (Berg, 2001).

- An Inductive approach involves coding categories that are derived directly from the raw data, like the approach used for grounded theory development by Hsieh and Shannon (2005). The Inductive analysis is similar to that adopted in phase one of the research raised through the ideas obtained in the focus group.

Krippendorff (2004) posits that all reading of texts is qualitative even when converted into numbers. Thus the intention to opt for the qualitative content analysis approach in this study was two-fold: to elicit new information from current understanding of the TA concept and to heighten therapist awareness on complex interpersonal processes involved in achieving successful outcomes. A qualitative content analysis methodology seemed to serve two purposes in the initial data collection, which would endorse the development of the investigation through phases two and three.

2.3.6 Phase One: Focus Group NVivo 10: Computer Coding Analysis

Open coding is the 'first pass' through the data to locate themes and assign category titles; it includes 'in vivo' coding, which derives codes directly from the data (Bazeley & Jackson, 2013) using specific words and phrases from the content in the transcript.

The next phase is 'axial coding' which involves clustering and eliminating categories, as the researcher gets deeper into the data. 'Selective coding' is the deepest level of analysis as the researcher chooses themes and compares and contrasts data after all the data collection is completed. This is the final stage of analysis.

The coding in this study provides 'first pass' 'in vivo' coding, and 'axial coding'. The analysis process involved axial and selective coding to help merge some of the subcategories in the tables into broader categories for interpretation.

Transcribed word files are titled to take advantage of the content in the coding reports sorted alphabetically according to the titles of the interviews, assuming text has been coded from those documents. Since there is only one interview in this phase of the study, the title was simply 'Focus Group'.

2.3.7 Phase One: Focus Group Transcript Analysis: Initial Statements

An initial 51 statements were generated from the focus group transcript and manual analysis to assist the process in constructing the new TA measure. This procedure led to

'phase two' of the research. Statements were constructed reflecting actual discourse covering a wide range of potential TA elements. Several other methodological factors were taken into account at this point, as described by Loewenthal (2001) and Cheung and Renswold (2000). These included:

- Face validity
- Content validity
- Lack of ambiguity
- Not double-barrelled
- Reverse meaning
- Social desirability
- Offensiveness.

For example, 'face' or 'content validity' refers to how the statements appear to fit the content that reflects the topic to be assessed. Prior to 'phase two' of the data collection, all statements were checked independently by five professional therapist colleagues who assessed for ambiguity and grammatical errors that could be confusing for the respondent in providing an appropriate answer. In the initial statements only one statement needed slight amending (statement 51) that potentially could have been ambiguous. This was subsequently amended.

The remainder were described as clear and fit for the topic in question. It was also important to address whether statements might have had a double-barrelled meaning, such as asking two questions in one. To avoid a confounding effect called response bias or 'Response Acquiescence Set' (a concept where respondents to questionnaires tend to agree rather than disagree), a mixture of unpredictable negative and positive items towards the TA needed to be present (Cheung & Renswold, 2000). However, note that when compiling the final statements for the online survey, the Thurstone scaling model (Elder et al., 1980) was adopted requiring scoring on items in ascending order (1-11) most favourable to the concept of the TA. To impose negative comments on the TA at this point would naturally be counter-productive to the research, although participants could still rate either high or low on the scale to show to what extent they agreed with each item.

Social desirability effects was another possibility where respondents are suggested to provide socially accepted answers that make them look good, although in this context, Loewenthal (2001) posits this can be difficult to control. Nonetheless, the researcher

was mindful of such effects, but it was anticipated that the inclusion criteria for participation in this study would mean participants such as therapists and trainees would answer honestly as part of their professional integrity, not only for the benefit of gaining more understanding on the TA concept and what is involved, but being honest with responses would naturally support their own ethical practice. Finally, for ethical and pragmatic reasons, the researcher ensured sensitivity prevailed towards the topics, and within the context of obtaining opinions and beliefs in the process of social research.

2.3.8 Phase Two: Rationale for a Hybrid Thurstone-Likert Model

A hybrid Thurstone-Likert model was first conceived by Oppenheim (1992). According to Fishbein (1967), both types of scaling confront respondents with affective scores that can be summated.

2.3.9 Phase Two: Rationale for Thurstone Scaling and Panel Judges

In the Thurstone equal-appearing interval model and psychological scaling, the intervals between categories are subjective. Although Oppenhiem (1992) claims that as panel judges, participants take an objective stance on the relevance of each item (stated in section 2.2.7, p.70), the term 'objective' in this context, was perceived by the researcher to mean 'professional judgement', because it is widely acknowledged within the humanistic paradigm that humans base their views on their experiences thus it is unlikely that human participants can be totally objective in the context of social sciences research as opposed to external measurement, as found in the scientific/experimental method.

In this study, participants rated items most favourable to the concept of the TA, and rather than their own agreement or disagreement. The Thurstone technique eliminates items based on the criteria of reducing ambiguity and irrelevance. Likert-type scales look for undifferentiating items (Oppenheim, 1992). This is shown by judges' internal consistency, identified through semi-interquartile analysis, which shows the least variance across judge's scores in the development of the new TA measure items. Details of the semi-interquartile analysis can be found in Phase Two, section: 'Thurstone Model: Analysis Process'. Thus a hybrid methodology as shown in this study, employs a clearly defined step-by-step application.

For clarity on the research design, the Thurstone model forms part of 'phase two' of the data collection, and Likert-type survey scaling is attributed to 'phase three' – Part A.

When researching a qualitative subject like the TA, to strengthen the data in constructing a new TA measurement scale a Thurstone methodology has several advantages listed below. Likert-type scaling advantages are shown in the subsequent section (Phase Three–Part A).

1) It is a based on a discrimination paradigm, which is embedded in a strong theory of human-processing. For example, Thurstone defined discrimination as the process by which an organism identifies, distinguishes, or reacts to stimuli, or in other words—a basic operation of judgement in generating knowledge, yet as humans, not absolute (Krabbe, 2008);
2) It can transform subjective rank order data to a single group composite interval scale (Krabbe, 2008);
3) Scaling involves a spectrum of equal-appearing values from negative to positive (Arons, Krabbe, Schölzel-Dorenbos, Gert Jan van der Wilt, & Olde Rikkert, 2012).
4) Thurstone scaling offers objective measurement (explained above) and scoring that is independent of raw data (Kline, 2000).

2.3.10 Phase Two: Thurstone Scaling: Analysis Process

According to Thurstone and Chave (1929), equal-appearing intervals methodology is a technique "of evenly graduated opinions so arranged that equal steps or intervals on the scale seem to most people to represent equally noticeable shifts in attitude" (p. 554). In the first instance, a range of items is generated (as in this study) through the transcription of the focus group interview. The next stage is to compute the mean, mode, and median. The median calculates each participant's responses that are above and below 50% of which the ratings and the interquartile range are ascertained. This is the difference between the score, which has one quarter of the scores below it, known as the first or 25^{th} quartile (Quartile 1), and which has three quarters of the score below it, known as the third quartile or 75^{th} quartile (Quartile 3) - see Robson (2011) for measures on variability. A semi-interquartile range (Clark-Carter, 2005), which is half the interquartile-range then identifies the least variability across panel judges' responses, which helps establish the items for rating on the new TA measurement scale to be entered into the survey.

2.3.11 Phase Three-Part A: Rationale for Likert-Type Scaling: Online Survey Respondents

An online survey that employs Likert-type responses (Likert, 1932) is a good way to obtain a large sample size, which increases validity on findings (Hartley, 2013). In scale development, a researcher can choose the number of points on the scale. In this study, items were rated from Strongly Disagree = 1, Disagree = 2, Neutral = 3, Agree = 4, Strongly Agree = 5. For the type of participant needed in this survey (therapists—all busy professionals) this type of data collection meant less time was required to participate in the research. Survey scales can be effective in the development of highly reliable scales and deemed less laborious to the aforementioned Thurstone scaling (Anderson, 1981).

2.3.12 Phase Three-Part A: Likert-Type Scaling: Analysis Process

In the final phase of the data analysis on survey responses, exploratory factor analysis (EFA) was employed, which is a statistical technique widely used to develop scales and subscales (Gorsuch, 1983). EFA (like Principal Components Analysis (PCA)) is a variable reduction technique, but EFA identifies the number of latent constructs and the underlying factor structure of a set of variables (Child, 1990) whereas PCA is only used to summarise observable data (Matsunaga, 2010). Thus, when a researcher has no complete expectations on the underlying structure of correlations, in this case, those that actually make up the TA, procedures such as EFA (Fabrigar & Wegener, 2012) exist to allow for exploration in the process of gaining new insight into the construct under investigation.

2.3.13 Phase Three-Part B: Exploratory Factor Analysis: Analysis Process

The Kaiser–Meyer–Olkin (KMO) ‘measure of sampling adequacy’ (MSA) and Bartlett’s test of sphericity are two tests performed to help determine whether the common factor model is appropriate (Brace, Kemp, & Snelgar, 2006). It is important to check that the KMO value is .6 or above (Pallant, 2005). The Bartlett’s test value should be .05 or smaller.

Kaiser has described MSAs above .9 as marvellous, above .8 as meritorious, above .7 as middling, .6 as mediocre, .5 as miserable, and below .5 as unacceptable (Levine, Kaplan, Kripke, Bowen, Naughton, & Shumaker, 2003).

To ensure the data are suitable for factor analyses, in EFA there is a criterion used for extracting factors described in detail by Brace, Kemp, and Snelgar (2006). These are as follows:

- **Kaiser's criterion** – identifies the eigenvalues for the correlation matrix and shows how many of the eigenvalues are above one. The number of eigenvalues above one then helps identify the number of factors to include for extraction.

- **Cattell's scree plot** – shows how the eigenvalues are initially considered. Attention is given to the elbow-like break where the plot levels out. This indicates the number of factors for extraction.

- **Percentage of variance** – shows the common variance that is explained by successive factors.

- **Parallel Analysis** – Monte Carlo PCA, a statistical program developed by Marley Watkins (2006). This program calculates 100 equivalent random sample sizes and variables to the actual sample size and variables in this study. If eigenvalues above one are greater in the original data than in the random data, factors are retained. If they are lower they are rejected.

Chapter 3: Results

3.1 Results Overview

The results from both the qualitative and quantitative analyses answer the two main research questions which asks, 1) "What are the perceived components and factor structure in therapeutic alliance measurement?" and, 2) "What does a sample of therapists think about the potential for a new measure to assist them in awareness of the therapeutic alliance?"

These questions will be discussed within Chapter 4. The results section consists of three parts:

3.1. Qualitative Content Analysis (QCA) results from the manual analysis (coding) of the focus group transcript followed by NVivo 10 computer coding, as both analyses were used to validate TA themes

3.2 Semi-interquartile range results from panel judges' responses

3.3 Quantitative results from the EFA analyses.

3.1.1 Qualitative Content Analysis - Focus Group Manual Coding

The purpose of manually scrutinising the transcript data was to see what information might emerge that may not be detectable through computer analysis and vice versa (Welsh, 2002). Manual coding is not an exact science, but interpretative by the researcher (Saldaña, 2009).

The manual analysis of the focus group transcript applying the technique of 'in vivo coding' described by Saldaña (2009) resulted in the following themes, which attributed to the factor structure identified through the EFA on how therapists develop and maintain the TA. Themes presented from participants' quotes, are clustered and show quotes from the beginning of the line number. Responses: such as 'mms' and 'yeahs' are also numbered in the transcript. The quotes offered in the following sections are believed to be the best examples that supported key questions which emerged in the data by applying the principles on methodology factors as described in section 2.3.7, by Loewenthal (2001) and Cheung and Renswold (2000). Line numbers are stated at the end of each indented quote and where applicable, are documented at some points in the main text.

Themes include:

- Client pre-therapy expectations
- Client pre-therapy communication
- Ethics
- Managing challenges in therapy
- 'Being with the client'
- Explicit communication
- Implicit communication
- Micro observations
- Belief in client's ability
- Instinct
- Therapist self-awareness.

When considering TA measurement, the following themes materialised:

- Uncertainty
- Different perspectives
- What is being measured (misunderstandings)?

- Who should measure TA?
- Timing of measurement
- Accuracy
- Numerical TA measurement
- Therapist performance
- Benchmarking
- Measurement advantages and disadvantages

Five key questions emerged from the focus group discussion which helped consolidate the data and support the findings of the manual QCA. These are stated within section 3.1, under the following sections:

3.1.2. What Is The Therapeutic Alliance?
3.1.3. When Does The Therapeutic Alliance Start?
3.1.4. How Do Therapists Develop The Therapeutic Alliance?
3.1.5. How Do Therapists Maintain The Therapeutic Alliance?
3.1.6. Is The Therapeutic Alliance Measureable?

A discussion on the results pertaining to each of these questions and reflections on the research methodology employed will be developed in Chapter 4. Note for reference, the transcript can be found in the appendices and line numbers from the transcript are in brackets at the end of quotes documented in the text.

3.1.2 What Is the Therapeutic Alliance?

In the following text, participants are offering interpretations of what they think the TA is.

> P.7 -"That is…that is…that is what happens there. And what you're saying about it being a two-way process, initially…and I think it can be either/or, but for me, I think yeah, perhaps it is me, the client, and the work is the space…the therapeutic alliance that happens between or actually perhaps we're all different so…but there's me, there's the client, and perhaps the work is the overlap in-between. And the alliance is that overlap in the middle." (769)
>
> P.4 - Is it the space or is it the overlap or could it be either? (770)
>
> P.3 - "It could be both". "It's about where you meet in the middle." (771)
>
> P.5 - "Chemistry. The atmosphere, the…the dynamics between us. And I think I'm very conscious in the way that I work of the kind of very much the core conditions, but with honesty and acceptance and that kind of …foundation of any alliance with a client I might work with." (17)

3.1.3 When Does The Therapeutic Alliance Start?

The results in this study have shown that the TA might well start sooner in some situations over others. Examples are shown in the following excerpts:

> P. 1 - "So do you feel you have to work harder in that initial se-…that initial sess-session to build up that contact and bond compared to if that had already started to be built up through…"I personally"—(another participant interrupts), "picture and phones!" (91)

> P.2 - "I certainly noticed a difference when the Internet started and we were able to do this. That I suddenly sort of found that I was getting the sort of people that, you know, wanted to come to the sort of therapist they thought I was. And it…a lot of the work had already"… "Yeah" (another participant agrees). "been done, you know. It's…it…it…it was really quite useful in terms of fit." (98)

> P.1. - "So people are able to kind of start the alliance if you like before they actually meet you and speak to you." (107)
> "Mm-hmm".
> P.7 - "But as we say in other settings, um you know, it's not until you actually invite them into the room that they actually know who you are." (109)

> P.6 - "I would say that the people I see who have never seen me…looked at the Internet or anything." (113)

> P.6 - "Yeah" (another participant interrupts but agrees) "are more nervous initially…than the people who come to me privately." (115-118)

3.1.4 How Do Therapists Develop The Therapeutic Alliance?

In developing the TA, the participants discussed different settings requiring different approaches.

> P.1 - "Respecting views of the client is quite important in what I do. Um and also funnily enough that the patient likes me [laughs] so I think that probably does make a difference to how my outcomes are or how I work with somebody…getting that feeling that you actually get on with somebody and then, you know, there's that sort of relationship there." (1)

In reply to the last quote, the following response was given.

> P.2 - "It's interesting 'cause I don't mind if a client doesn't like me as long as they respect what we're trying to do." (2)

> P.4 - "for me. Um not in both cases, but in…in the latter case. So…but ev-…even um, you know, the gathering information process…I guess in truth I do have a slight structure in my head. I know the things I want out of that first session, which sounds like what I want and not what the client wants. Some of it is…I should say probably 40%, 50% is what the client wants to talk about, wants to unload. But I definitely have a structure of things that I also want out of that session, um, which was gui-…I was

guided by…by my supervisor on that. Um and also for safety parameters, which of course includes contracting. Really important." (152)

P.5 - "…it's important for me with the therapeutic alliance to feel that I've…in that first session, made people feel…kind of feel at ease and um comfortable and safe. And then got some preliminary information and…and then done a little bit of work so that they've kind of got a flavour of well, this could actually, you know, make a bit of a difference to me." (209)

P.7. "But I also actually think it's about…for me, one of the foundations of the therapeutic alliance is acceptance of the person sat in front of me." (225).

P.4 – "For me, there's definitely two parts. There's me, the real me that's really important that I bring to that session. And if I'm anything else, the client's going to see straight through it. And that's the um client…that we had that ability…bit I feel they really accept and get in tune with. Um, however, the other part of me is, you know, I do have a um…I do have a, you know, an ethical framework. I work…an organization." (248).

P.3 "Yeah! I think what's most important uh for me in my relationship with clients is encouraging them to really, really trust their own sense of themselves and their own feelings. So I just keep putting it back to them. What do you feel? You know, what …in your body, what do you feel about that? And you know, refuse to be drawn on, you know, what do you think or, you know…it's…it's kind of what's your sense of yourself? Because they're…you know, that's what's, to me, is going to help the most in their life. To have confidence in that…inner sense of themselves. Yeah. And be…and be able to be guided by their own experience and sense of themselves." (365)

P.3 – "I feel that, too. I feel there's…the first session…those first couple of two sessions are so important in the process of building up the alliance. That we generate that feeling of potential or leaps of faith." (589)

3.1.5 How Do Therapists Maintain The Therapeutic Alliance?

The process of therapy not only relies on therapists developing the TA but maintaining it to avoid ruptures or disengagement. Examples of how the TA might be supported were described in the excerpts below:

P.2 - "I was told by a client once that I was trying to rush them to the goal. And rather than being stood next to them, I was in front of them pulling them along!" (255)

Another participant's immediate reaction to the above declaration from participant two, was one of feeling criticised (see appendix 14 - line 280) if they had received such a response from a client. The dialogue then continued as follows:

> P.2 – "Well, that…I…she could reflect that back, but then obviously we talked about it. (263) But we had developed such a relationship by that point… 'cause this was a long-term…um client…that we had that ability." (283)
>
> P.2 –"Yeah!...uh and… so yeah. It was really useful. And I just… we just then said afterwards, am I pulling, pushing, or by your side?" (287)
>
> P.1 – "So it has enabled… her honesty enabled the process almost as though it might have deepened a bit more or became…Your response to that could have made a br- you know, a make or break kind of therapy." (293, 296)
>
> P.4 – "Um so that the… the client really feels sort of …that they're not being [laughs] pulled or pushed or taken anywhere by you. That they can be themselves." (312)

In maintaining the TA, the results showed that participants realise the therapeutic process is never linear (Prochaska, Norcross, & Diclemente, 2013). Concluding this section, one participant in the focus group described the therapeutic encounter as 'like a dance' and went on to say:

> P.4 - "One person leads to begin with and then… and if you get out of step, then you trip over. I was thinking what type of dance do I do? I think I start off with slow waltz [laughs] very steady and sometimes somebody's jiving all around me." (935-941).

3.1.6 Is The Therapeutic Alliance Measurable?

The results below showed that participants offered much food for thought on TA measurement.

In the earlier part of the study within the sections in the literature review, an appreciation of the current position was given to the many aspects attributed to TA measurement, including the purpose of scales, scale sizing and amendments, by whom the scales are rated, and the different views on the TA as experienced by both clients and therapists. In the current section the results from the focus group transcript showed that several references were made to TA measurement.

Opinions were offered from therapists' perspectives, but simultaneously based on reflections of clients' responses in their therapeutic work. There were several references to how some clients found (or might find) numerical measuring of how they felt helpful, as well as ease of quantifying rather than qualifying their distress in the clinical sense. However, when considering quantifying the TA in the context of evidence-based practice on outcomes, this seemed to present more difficulties. The comments below

were developed from reflections on the two TA therapist version questionnaires used as optional prompts for discussion during the focus group data collection: The HAQ II – Therapist version (Luborsky et al., 1996). The WAI-S –Therapist version (Tracey & Kokotovic, 1989).

> P.4 –"I know what you mean about measuring and how clinical it is, and yet if as I maybe…and lots of people believe that therapeutic alliance is the process. It is where the work happens. Then in some way, you're going to have to measure it in today's society." (826)
>
> P.6 –"Completely. It's outcome-based. Everything is outcome evidence-based now. Um…and I don't believe it can't be done. Like I say it can be done. But perhaps not in the ways we've seen in these questionnaires." (827-828)
>
> P.6 –"But the problem is that measures are only about…they're only…they're kind of based on a person's perception of h-how they see it. And it may not be how someone else can see it. I mean I've had people s-score really high, you know, on a…you know, how you're doing. If you do like a rating scale of how you're doing, you know…and they…they put down 'everything's really great'. And yet when they tell you about their life, there probably isn't anyone else that would think, how could you [laughs] you know, that could agree that they're doing great. So it…you know, rating scales. It's in whose eyes? (833, 835, 837)
>
> P.1 –"So how else can…how else can we measure the therapeutic alliance?" (838)
>
> P.6 Oh, I don't know, but it's…it's…it's always going to…it's never going to be accurate is what I suppose I'm saying. It's never going to be…not everybody's ever going to always agree. That…that…it's not accurate because it depends on people's perceptions, doesn't it?" (839)

Participants then concluded:

> P.6 –"So there's never going to be 100% accuracy in any…No. Measure….and as long as that is recognised, I guess then that's what you can then subtract the kind of limitations…limited data from it." (903-908)

3.1.7 Qualitative Content Analysis - Focus Group NVivo 10 Coding

The focus group interview in this study provided rich and insightful comments relating to the therapeutic alliance concept. Following transcription and manual analysis, the interview was imported using NVivo 10 qualitative software and coded to three main categories 'Bordin-TA', 'Factors', and 'Measurement'. Each of these categories (themes) was coded to multiple subcategories, known as nodes. Nodes are points at which concepts potentially branch out into a network of sub-concepts (Bazeley &

Jackson, 2013). The computer findings support the manual coding as part of the QCA, in identifying any new TA themes.

Multiple 'specific factors' relating to the TA were identified under the parent node 'Factors'. Several subcategories reflected comments made regarding 'Measurement', and Bordin's concepts of attachment bond, shared goals, and tasks are subcategorised into several subcategories under each concept. Coding reports were organised into meaningful summary reports, shown in the 'Node listings' in the appendices.

The coding strategy provides reminders within various nodes rather than attempting to code every line of text to every single node possible. Coding for 'context' is especially important to provide meaning for analysis. The coding is an attempt to help guide the researcher/coder to sort out the comments with respect to those three areas.

NVivo inserts references and percentages in the coding reports when the reports are compiled, but they did not show momentous meaning in this study. The references relate to the number of times text was selected within the interview; the percentage is the percent of the document each selection represents. The percentages give an idea of proportionality of whether 'a lot' or 'a little' was coded from the interview to the category, but this can be less meaningful in short interviews such as was shown in this study.

In the excerpts below from the coding report 'Factors/Faith', two references (selections of text) were coded from the interview 'Focus Group', which represents 1.44% of the interview. The text coded is separated into reference one and reference two, and the percentage of coverage for each reference is also given; the reference percentages (0.68%, 0.75%) add to the total coverage 1.44%.

> **Name: Faith**
>
> <Internals\\Focus Group> - § 2 references coded [1.44% Coverage]
>
> Reference 1 - 0.68% Coverage
>
> P.1- So do you think we, as therapists then have to have some sense of hope for our clients then? Do we have to start that process off by having this sense that there is hope or there is some sense of --I think -- beginning or something? Is that how it starts?
>
> P.3 -I kind of interpret it a little bit of us having faith.

Mmm.
P.1 - So rather than having hope --
P.3 - Mmm.
P.1 - Yeah -- having faith. Yeah.
Reference 2 - 0.75% Coverage

P.1 - Yeah. For me, like I said, I think for me, potential. So it's same logic --
[laughs] -- different --
P.3 - Okay.-- different framing probably. I feel that, too. I feel there's -- the first session -- those first couple of two sessions are so important in the process of building up the alliance. That we generate that feeling of potential or leaps of faith --
P.1 - Mmm.
-- or hope. Just something --
P.3 - Planting a seed.-- Yeah. Exactly!

More examples are shown in the appendices.

The results showed that categories had multiple meanings and content was coded to multiple questions when relevant. Much of the discussion in the focus group focused on the client-therapist relationship as shown in the example below on coding 'Factors/Client-Therapist relationship'. The following selection was coded partially or entirely to 'Factors/Chemistry', 'Factors/Acceptance', 'Factors/Honesty', 'Factors/When therapeutic alliance happens', and possibly other categories as well.

There were many instances where everything could have been coded to 'Client-Therapist relationship', but because the idea within this part of the research investigation was inductive (Hsieh & Shannon, 2005), as well as deductive (Berg, 2001) based on Bordin's (1979) alliance theory, using one main code would not have been helpful in identifying new evidence on the TA. In the passage below F stands for Factor.

F. Chemistry: "The atmosphere, the… the dynamics between us. And I think I'm very conscious in the way that I work of the kind of very much the core conditions, but with honesty and acceptance and that kind of foundation of any alliance with a client I might work with".

3.1.8 Word Frequency Count Process: NVivo 10

Word frequency searches for the top 1000 words of an arbitrary number of characters. Three characters or more and five characters or more were chosen, as this analysis can be useful for content analysis of keywords and phrases. The 1000 word frequency list is available in two Excel files, *WF1000words3+char.xlsx* and *WF1000words5+char.xlsx.* NVivo 10 provides a default stop word list that is shown in the appendices.

Two “tag cloud” visuals were created from the Word frequency search showing words in various sizes according to the frequency with which they appeared. The visuals are displayed in the appendices. These visuals can also be helpful for unstructured data to help identify keywords to enable initial coding.

3.2 Panel Judges

Eleven panel judges rated 51 statements on an 11-point equal-appearing intervals scale (Thurstone & Chave, 1929).

In phase two of the data collection this included the panel judges who scored 51 statements most favourable to the concept of the TA. The semi-interquartile range analysis showed the least variation across judges’ scores (Table 3). These findings substantiate the ethical position of both focus group and panel judge participants and reflect many factors that are linked to current understanding on the TA regarding personal interactions and task-related work with a collaborate relationship. Items included:

- Gaining trust
- Not being judgemental
- Openness
- Structure
- Direction
- Facilitating opportunities for autonomy
- Empowerment
- Self-assessment
- Being mindful of chemistry
- Use of intuition
- Being liked or not being liked
- Awareness of when the TA begins
- Prioritising need
- Focus on non-verbal communication
- Client expectations
- Being flexible
- Pace
- Mindful of own well-being
- Duration
- Effects on relationship
- Informed consent
- Facilitating comfort and ease.

The scale was developed as unidimensional and measured responses from one representing least favourable to 11 representing the most favourable. In this type of methodology, the median and semi-interquartile range (SIQ) is calculated on all item

responses for each participant (see appendices). Ideally, there would be median values for each of the 11 scale values and items chosen from each value with the lowest SIQ. (The lowest SIQs indicate the least variability across judges' responses, which helped identify items selected for the new TA measure). However, in this study this was not the case. For example, there were no 1, 2, or 5 median values recorded in the median analysis as displayed in Table 3, leaving just eight values in total to be considered for the final item selection.

Table 3: *Statement (item) Analysis*

St. no.	Median	Mean	SIQ
30	3	4.27	2
5	4	4.45	2
18	4	4.81	2.5
2	6	6.36	1.5
3	6	5.81	3
28	6	5.81	2
37	6	6.45	2.5
22	7	7.00	3.5
27	7	7.18	1.5
32	7	7.00	0.5
36	7	6.18	2.5
39	7	7.27	3
42	7	6.18	3.5
45	7	7.00	2
11	8	8.36	1
12	8	8.63	2
14	8	8.00	1.5
15	8	7.63	1.5
21	8	6.54	2
23	8	7.63	1.5
24	8	7.72	1
29	8	7.72	2.5
31	8	7.63	2.5
33	8	6.81	2.5
34	8	8.45	1.5
47	8	8.18	0.5
48	8	8.00	2
49	8	7.63	2
10	9	8.63	1.5
16	9	8.90	1
20	9	9.09	1
38	9	9.36	1

40	9	8.72	1
41	9	8.72	1.5
46	9	8.54	2
50	9	9.36	1
51	9	9.36	1.5
1	10	9.18	1.5
6	10	8.63	1
8	10	9.90	1
9	10	9.36	1.5
13	10	8.63	1
25	10	9.90	1
26	10	9.45	1.5
35	10	9.72	1
43	10	9.27	1.5
44	10	9.36	1.5
4	11	10.18	1
7	11	10.36	0.5
17	11	9.36	1.5
19	11	10.00	1

Table 3: shows median, mean, and SIQs ranges. Final 22 items (St.no) for the new TA measure survey are highlighted in bold.

To account for the missing values, the nearest lowest values (3, 4, 4) were selected because these were the lowest three values with the smallest SIQ which demonstrates fairness in respect to low and high values for all response scores, on the initial 51 items. This left five more values to be considered, to total the eight values recorded. To establish the final 22 items to be entered into the online survey, at least three items per value were considered, as this gave an approximate amount of items for each value exceeding 22. As you will see in Table 3, there was only one median value of 3, (Statement number 30 and SIQ equal to 2) which meant this item was automatically selected for the final items to account for responses across the range of values recorded. In Table 3, also note there are seven items within value 7, thus the smallest SIQ within each value becomes important because there are more than three items recorded with a value of 7. Therefore in this instance, the three items selected with the lowest SIQs with a value of 7 were item 32 = 0.5, item 27 = 1.5, and item 45 = 2. Consideration in choosing the number of items from each median value was also given a value of 8. Here you will see there are 14 items in this value. Thus to offset this, larger number of values and subsequent items, as well as thoughts on the theoretical implications on responses in this median, four items were selected from the value of 8 with the lowest SIQs, to

again achieve a fair distribution of items across values in making up the final 22 items for the TA measure.

The last step in acquiring the final items for the TA measure meant a reflection on the researcher's part, on all statements on all median values. For example, as Trochim (2006) suggests, the final items should not just be considered statistically. Thus in addition to the steps in the analysis stated above, several more issues were taken into account on each of the median values to acquire the final 22 items. These are as follows:

- Items were representative of a unidimentional scale, favourable to the concept of a positive TA and reflecting the current TA theoretical position;
- Items showed differences that cover a broad range of salient factors throughout the TA process, for example, they related to thinking about the process (see appendices) (items one and twelve) as well as being in the process (see items two and three);
- Items considered existing, well-documented TA models in relation to Bond, Tasks, and Shared Goals;
- Items included verbal and non-verbal communication;
- Items reflected being alert to challenges in the relationship;
- Items did not appear too similar.

The following sections are the results for the exploratory Factor analysis (EFA).

3.3 Quantitative Results Overview

In phase three (part A), participants completed all 27 items in the online survey rating the final 22 items for the new TA measure constructed through the analysis on panel judges' scores. A further four items included participants' opinions on whether the factors identified in the new TA measure could heighten therapists' awareness and assist them in training, their views considered in practice (generally), in clinical supervision, and in their own practice? A final item requested opinions on whether a TA measure was necessary in therapy. All responses to the 27 items were obtained via a five-point scale. In phase three (Part B) EFA was conducted on survey scale responses.

To help answer the first research question (What are the perceived components and factor structures in therapeutic alliance measurement?), the EFA included two rotational methods: 'varimax' that identifies uncorrelated items and the 'direct oblimin' rotation that identifies correlated items. The first two of the three 'factor loadings' (clusters of

items) emphasized relationship-building (Factor 1) and managing the process (Factor 2). These findings indicate that during the process contributions that the therapist brings to the therapeutic relationship (by way of skills, knowledge, techniques and tasks, and pre-therapy process) predominate over the relational bond (Factor 3) or attachment bond elements, albeit each of the first two factors include relational features at the explicit and implicit level (Table 9).

To support these findings, as well as out of curiosity, further consideration was given to whether Factor 1 and Factor 2 (although having different functions as identified through their respective names) might be measuring the same construct (task) as opposed to factor loadings in Factor 3. Thus a two-factor varimax rotation was subsequently performed on the survey responses. These results showed that Factor 1 and Factor 2 were almost identical to the aforementioned three-factor analysis. However, what was interesting in the two-factor analysis was that Factor 3 items (17, 18, and 21) identified in the three-factor analysis did not load onto either of the two task factors. This suggested that Factor 3 is measuring something different than the two other factors, 1 and 2 (which appear both explicit in nature). Items 17, 18, and 21 significantly loaded onto Factor 3 as in the first rotation and are measuring something implicit in the context of the relational or attachment bond. The output from the two-factor analysis is documented in the appendices. It was decided to report the varimax three-factor structure to represent both explicit and implicit items which best reflect the theoretical position on the TA construct. A three-factor structure also incorporates all views of the participants within this research investigation.

The results below provide the factor structure identified from the EFA analyses developed through the qualitative analyses stages, which led to these results.

Three main factors that help develop and maintain the TA were identified in the EFA as:

1) Relationship-building,
2) Managing process,
3) Relational bond.

Tabachnick and Fidell (2001) suggest a general rule on loadings showing that “the greater the loading, the more the variable is a pure measure of the factor” (p. 625). In order of

significance ‘factor loadings’ (cluster of items) on each of the three factors are as follows:

Factor 1: Relationship-building, item 7: .671 (very good), item 6: .649 (very good), item 22: .567 (good).

> 07. Offering reassurance on confidentiality and boundaries helps a client feel safe.
> 06. Not judging a client gives them a sense of feeling safe.
> 22. A therapist needs to be mindful of his or her own well-being on performance when offering therapy.

As shown in items 7 and 6, there is clearly an emphasis on task and the responsibilities that therapists have on relationship-building. In item 22 therapists’ responsibilities are still task-related, but the task in this item is aimed at therapists themselves.

Factor 2: Managing the process, item 4: .650 (very good), item 10: .625 (good), item 15: .624 (good).

> 04. A basic structure with general questions in the first session helps a client feel at ease.
> 10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.
> 15. A client needs direction in therapy to help the process.

Items 4, 10, and 15 above give clear indication of therapist tasks, but these items lean towards the responsibilities of therapists in managing the process of therapy.

Factor 3: Relational bond, item 18: .581 (good), item 17: .457 (Fair), item 21: -.443 (fair). Note that item 21 is negatively significant suggesting this item could have been reverse-scored.

This item has been scored as ‘fair’ because statistically if it had been reverse-scored it is nearer .45 than .32. According to Tabachnick and Fidell (2001), .32 would be regarded as poor.

> 18. Chemistry needs to be present in the relationship to achieve a successful outcome.
> 17. A therapist needs to bring their professional and personal self into the relationship.
> 21. A client does not have to like the therapist as long as they like the work being done.

3.3.1 Exploratory Factor Analysis Overview

The purpose of EFA was to investigate the data structure for the 27 items generated through the data collection and analyses in phase one and two of the study. For survey questions Q1- Q22, this involved using multiplied scores, and Q23-Q27 involved using

the original scores. Each measure (item) is in a five-point scale: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree. There were also seven demographic questions, three yes or no questions, and one open-ended question, as detailed below.

Please note: although there were originally nine demographic questions: job title, years' qualified, current qualification, therapeutic orientation, gender, age range, plus three 'TA use' questions. In phase three there were 11 demographic questions presented to participants. This was due to an after-thought, which meant in the online survey there was an additional demographic question included: "previous role" as well as an open-ended question (If applicable, please state in the box below which Therapeutic Alliance measure/s you currently use? State NA if don't use any, or state another form of how you measure the Therapeutic Alliance). However, these two questions were not added into the data and results of this study because it was decided by the researcher that to show fairness to all participants, demographic information obtained should be exactly the same for all. For reference, the information is displayed in the appendices.

The three yes or no questions (Table 5):

- I use a Therapeutic Alliance measure in every therapy session.
- I use a Therapeutic Alliance measure at the beginning and end of therapy.
- I use a Therapeutic Alliance measure randomly in therapy sessions.

3.3.2 Descriptive Statistics

One hundred and six participants responded to the online survey in the study. Ninety-one participants completely answered all 27 scale items (statements). Initially, analysis was carried out to run descriptive statistics (Table 4) and then on yes or no answers on whether participants use a TA measure (Table 5). When running the SPSS analysis on descriptive statistics, the next step was to input missing data on 106 participants, including the two options 'exclude pairwise' and 'list-wise' (the latter, excludes cases with missing values) yet results presented very similar both ways (equal to 91 respondents). Hence, only 91 participants with complete answers for all 27 items were entered for data analysis in this study.

Table 4: *One-way frequency of demographics*

		Frequency (Percentage)
Job title	Counsellor	44 (51)
	Psychologist	12 (14)
	Psychotherapist	12 (14)
	Trainee	18 (21)
Current qualification	Diploma	40 (47)
	Masters	8 (9)
	PhD	13 (15)
	Psych-Doctorate	25 (29)
Orientation	Cognitive Behavioural Therapy	16 (19)
	Brief Solution Focus	1 (1)
	Psychoanalytical	3 (3)
	Psychodynamic	10 (12)
	Person-Centred	27 (31)
	Systemic	1 (1)
	Integrative	18 (21)
	Existential	3 (3)
	Other	8 (9)
Gender	Female	76 (89)
	Male	9 (11)
Age-range	18-30	7 (8)
	31-40	19 (22)
	41-50	21 (24)
	51-60	26 (30)
	61+	13 (15)

Table 4: Job title = 5 missing values, Current qualification = 5 missing values, Orientation = 5 missing values, Gender = 6 missing values, Age-range = 5 missing values.

Table 5: *One-way frequency table of the three yes or no questions*

Question		Frequency (Percentage)
I use a Therapeutic Alliance measure in every therapy session	Yes	2 (2)
	No	83 (98)
	Missing	6
I use a Therapeutic Alliance measure at the beginning and end of therapy	Yes	10 (12)
	No	74 (88)
	Missing	7
I use a Therapeutic Alliance measure randomly in therapy sessions	Yes	17 (20)
	No	67 (80)
	Missing	7

Table 5 shows the frequencies and percentages for the degree of use of TA measure.

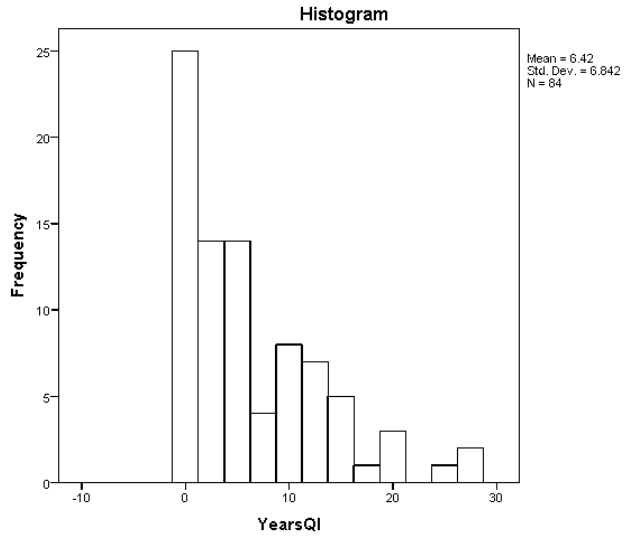

Figure 1: shows the Histogram of Years qualified (years Ql). The average years qualified was 6.42 with standard deviation = 6.84. The minimum, maximum, and median of years qualified are 0, 27, and 4, respectively.

3.3.3 Exploratory Factor Analysis Results: Q1-Q22

From the 51 statements generated via the focus group transcript 22 items were retained for the survey/TA new measure and then renamed as items Q1-22 (see appendices). In the survey development (created through the online website 'Survey Monkey') all items are formatted and listed as questions regardless of whether they are questions or statements. In the main, the 22 items were not listed in any particular order from 1-22. However for logical reasons, any statement that made reference to the initial part of the therapeutic process, which was the case in Statement 19, became Q1 because it refers to when the TA starts. Those items which reflected being further on in the process, were subsequently placed, and so on. As part of the hybrid Thurstone-Likert model, items Q1-Q22 were each multiplied (rescaled from raw data scores) by the underlying weighting score (derived from the process using the 11 judges and SIQR sifting (Table 3). The weighting scores are: 11 (Q1), 10 (Q2), 11 (Q3), 7 (Q4), 6 (Q5), 10 (Q6), 10 (Q7), 11 (Q8), 8 (Q9), 4 (Q10), 9 (Q11), 8 (Q12), 7 (Q13), 6 (Q14), 6 (Q15), 9 (Q16), 8 (Q17), 4 (Q18), 3 (Q19), 8 (Q20), 7 (Q21), and 9 (Q22). For example, participant one answered 4 for Q1, so the weighting score for Q1 is 11 - the score for participant is 4 x 11 (44). Participant three answered 4 on question 4 - the weighting score for Q4 is 7, so the score for participant 3 is 4 x 7 (28). The same procedure was applied to all questions.

Table 6: *Mean and standard deviation*

	Mean	SD
1. The therapeutic alliance starts when the first contact is made with the client.	49.68	9.04
2. Gaining client trust is something that needs working on right from the start.	46.92	5.31
3. In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe.	51.37	6.36
4. A basic structure with general questions in the first session helps a client feel at ease.	25.54	6.87
5. Formal assessment of need in the first session is not important in alliance-building.	17.80	6.48
6. Not judging a client gives them a sense of feeling safe.	44.62	7.04
7. Offering reassurance on confidentiality and boundaries helps a client feel safe.	45.05	5.84
8. Openness and being genuine on both parts within the relationship support the therapeutic alliance.	50.29	7.72
9. A focus on non-verbal communication helps the relationship and process.	31.38	6.45
10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.	12.13	3.65
11. A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.	39.46	5.97
12. A client who feels powerless can project power onto the therapist.	32.35	4.90
13. Being liked by the client helps build rapport and supports the therapeutic work.	24.77	5.74
14. Intuition tells you the process is working well.	21.69	4.36
15. A client needs direction in therapy to help the process.	17.87	5.51
16. In a brief therapy service, client expectations should be explored, and service provision explained right from the start.	39.96	4.69
17. A therapist needs to bring their professional and personal self into the relationship.	30.59	7.01
18. Chemistry needs to be present in the relationship to achieve a successful outcome.	10.99	3.40
19. The longer a therapist works with a client the better the relationship becomes.	8.11	2.59
20. A client self-assessment scale could be effective when reflecting own progress.	27.69	6.35
21. A client does not have to like the therapist as long as they like the work being done.	23.46	6.12
22. A therapist needs to be mindful of his or her own well being on performance when offering therapy.	38.67	5.77

Table 6 shows mean and standard deviation (SD) of Q1-Q22 after rescaling. N = 91.

Prior to further analysis a test of normal distribution was carried out on the survey responses: Table 7, below.

Table 7: *Tests of Normality*

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
1. The therapeutic alliance starts when the first contact is made with the client.	.359	91	.000	.600	91	.000
2. Gaining client trust is something that needs working on right from the start.	.444	91	.000	.595	91	.000
3. In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe.	.441	91	.000	.598	91	.000
4. A basic structure with general questions in the first session helps a client feel at ease.	.222	91	.000	.889	91	.000
5. Formal assessment of need in the first session is not important in alliance-building.	.221	91	.000	.893	91	.000
6. Not judging a client gives them a sense of feeling safe.	.360	91	.000	.713	91	.000
7. Offering reassurance on confidentiality and boundaries helps a client feel safe.	.351	91	.000	.708	91	.000
8. Openness and being genuine on both parts within the relationship support the therapeutic alliance.	.389	91	.000	.631	91	.000
9. A focus on non-verbal communication helps the relationship and process.	.307	91	.000	.826	91	.000
10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.	.211	91	.000	.894	91	.000
11. A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.	.296	91	.000	.753	91	.000
12. A client who feels powerless can project power onto the therapist.	.331	91	.000	.765	91	.000
13. Being liked by the client helps build rapport and supports the therapeutic work.	.252	91	.000	.868	91	.000
14. Intuition tells you the process is working well.	.262	91	.000	.838	91	.000
15. A client needs direction in therapy to help the process.	.216	91	.000	.899	91	.000
16. In a brief therapy service, client expectations should be explored, and service provision explained right from the start.	.350	91	.000	.675	91	.000

17. A therapist needs to bring their professional and personal self into the relationship	.272	91	.000	.857	91	.000
18. Chemistry needs to be present in the relationship to achieve a successful outcome.	.217	91	.000	.878	91	.000
19. The longer a therapist works with a client the better the relationship becomes.	.243	91	.000	.845	91	.000
20. A client self-assessment scale could be effective when reflecting own progress.	.312	91	.000	.809	91	.000
21. A client does not have to like the therapist as long as they like the work being done.	.276	91	.000	.855	91	.000
22. A therapist needs to be mindful of his or her own well being on performance when offering therapy.	.294	91	.000	.761	91	.000

Table 7: shows that in column 4, the sig. value is below 0.05, which means the data is not normally distributed.

For reference, two examples of differences in distribution on survey responses in items 2 and 10 are shown below in Figures 2 and 3.

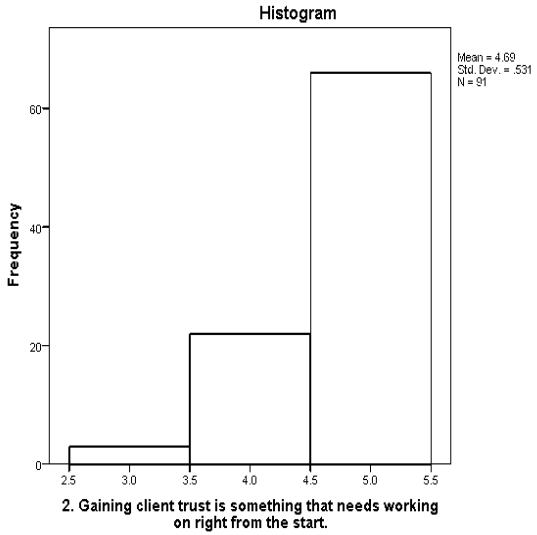

Figure 2

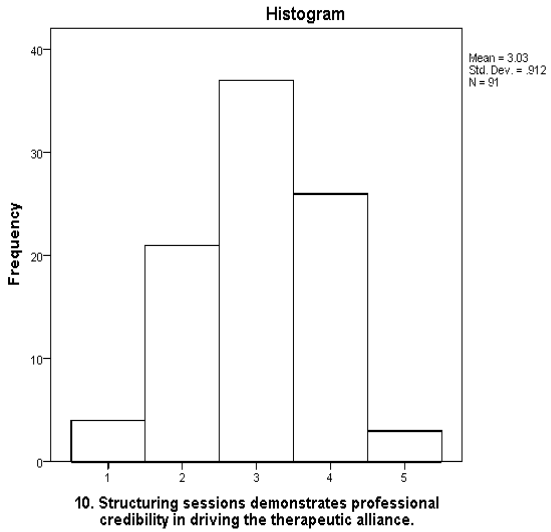

Figure 3

The EFA method used in this study was 'principal axis factoring' (PAF) (Field, 2013). PAF can be the preferred method of extraction if distribution is not normal (Fabrigar et al., 1999).

The two rotation methods performed were:

- The varimax rotation, an orthogonal rotation used in order to obtain analytical measure of a simple structure. Note that an orthogonal rotation means that the factors are independent of each other (they are uncorrelated);
- The direct oblimin method: an oblique rotation method. Oblique rotations allow some correlation among the factors (Tabachnick & Fidell, 2007).

In order to determine the number of factors that should be retained, the scree plot is displayed in Figure 4. The scree plot is created to show the relationship between the eigenvalues and the 22 items. The elbow break suggested that three to four factors should be extracted, as it is where the plot abruptly levels out.

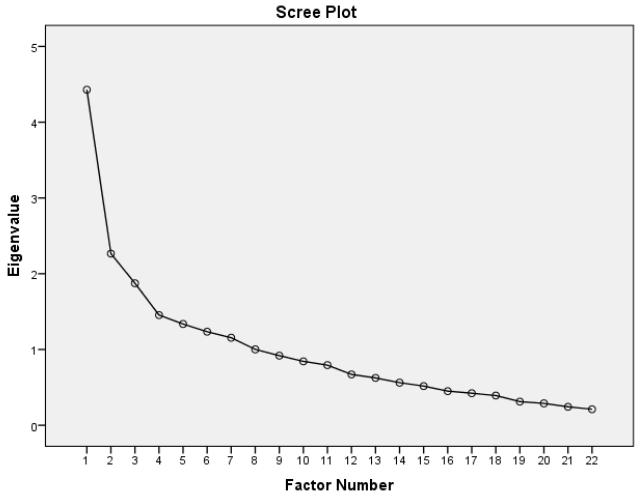

Figure 4: Scree plot

Using the following setting, number of variables = 22, number of participants = 91, and number of replications = 100, the results of the parallel analysis (Watkins, 2006) indicate that three factors should be retained. The results of the parallel analysis are displayed in Table 8.

Table 8: *Monte Carlo Parallel Analysis output, Q1-Q22*.

Eigenvalue number	Random Eigenvalues	Standard Deviation	Actual Eigenvalues	Eigenvalues for Extraction
1	2.017	0.103	4.428	Retain
2	1.815	0.076	2.266	Retain
3	1.668	0.062	1.874	Retain
4	1.555	0.052	1.454	Reject

3.3.4 Varimax Orthogonal Rotation

Table 9 shows the factor loadings for the three factors after the varimax rotation. The greater the loading, the more the variable is a pure measure of the factor.

Although preferences for cut-offs can be down to the researcher, Tabachnick and Fidell (2001) suggest that the general rules of loadings in excess of:

- 0.71 are considered excellent;
- 0.63 are considered very good;
- 0.55 are considered good;
- 0.45 are considered fair;
- 0.32 are considered poor.

Thus it was decided in this study 0.40 was the cutoff value because several loadings in the rotations were nearer to 0.45 than 0.32, so called for further theoretical consideration.

- The items significantly loaded on the first factor are: 2, 3, 6, 7, 11, 16, and 22.
- The items significantly loaded on the second factor are: 4, 10, 13, 15, and 20.
- The items significantly loaded on the third factor are: 17, 18, and 21.

Note: that for factor 3, the loading of Q21 is negative, indicating that Q21 might need to be reverse-scored. This will be discussed in Chapter 4.

Table 9: *Rotated factor loadings, varimax rotation. The subsets that significantly loaded on each of the factors are shown in bold.*

	Factor		
	1	2	3
7. Offering reassurance on confidentiality and boundaries helps a client feel safe.	**.671**	.124	-.045
6. Not judging a client gives them a sense of feeling safe.	**.649**	.173	.140
22. A therapist needs to be mindful of his or her own well-being on performance when offering therapy.	**.567**	.200	.054
2. Gaining client trust is something that needs working on right from the start.	**.559**	.160	.089
16. In a brief therapy service, client expectations should be explored, and service provision explained right from the start.	**.547**	-.001	-.016
11. A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.	**.515**	.007	.050
3. In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe.	**.458**	.376	.138
12. A client who feels powerless can project power onto the therapist.	.399	-.006	-.168
8. Openness and being genuine on both parts within the relationship support the therapeutic alliance.	.385	.172	.322
9. A focus on non-verbal communication helps the relationship and process.	.300	.084	.110
4. A basic structure with general questions in the first session helps a client feel at ease.	.115	**.650**	-.112
10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.	.167	**.625**	.051

15. A client needs direction in therapy to help the process.	.032	**.624**	.093
13. Being liked by the client helps build rapport and supports the therapeutic work.	.043	**.584**	.298
20. A client self-assessment scale could be effective when reflecting own progress.	.182	**.537**	.063
18. Chemistry needs to be present in the relationship to achieve a successful outcome.	-.041	.085	**.581**
17. A therapist needs to bring their professional and personal self into the relationship.	.297	.011	**.457**
21. A client does not have to like the therapist as long as they like the work being done.	.124	-.217	**-.443**
14. Intuition tells you the process is working well.	.238	-.079	.364
19. The longer a therapist works with a client the better the relationship becomes.	.008	.039	.291
1. The therapeutic alliance starts when the first contact is made with the client.	.003	-.038	-.259
5. Formal assessment of need in the first session is not important in alliance-building.	.213	-.114	.238

The prior communality estimate for each variable was set to its squared multiple correlation with all other variables. Kaiser's MSA and Bartlett's test of sphericity indicate whether the partial correlations among variables are small and indicate the common factor model is appropriate. The Kaiser's MSA = 0.662 and Bartlett's test of sphericity was significant (p = 0.000).

Table 10 shows the final communality estimates. The communality estimates for the 22 measures (items) represent the proportion of variance of each of the 22 measures shared by all remaining measures. That is, the communalities are the estimated proportion of the variance of the variables that contributed to the common factors (common factors = 3), meaning, the proportion of each variable's variance that can be explained by the common factors. For example, the communality estimate for Q1 is 0.069, which means that only 7% of the variance of the measure item Q1 is shared by all other measures. Or put another way, 7% of the variance of the measure Q1 can be explained by the three common factors, which indicates that this measure, to some extent, is a different construct than the other measures. Taking into account that variables with high values are well represented in the common factor space, while variables with low values are not well represented, a small communality estimate might indicate that the variable may need to be modified or even dropped.

The sum of all communality estimates (6.559) is the estimate of the common variance among all 22 measures. This estimate of the common variance contributes about 30% (6.559/22 = 0.2981) of the total variance present among all 22 measures.

Table 10: *Final communality estimate, varimax rotation. Total = 6.559, the sum of the final communality estimates. Items not highlighted were considered to have small communality estimates.*

	Final communality estimate
1. The therapeutic alliance starts when the first contact is made with the client.	0.069
2. Gaining client trust is something that needs working on right from the start.	**0.345**
3. In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe.	**0.370**
4. A basic structure with general questions in the first session helps a client feel at ease.	**0.448**
5. Formal assessment of need in the first session is not important in alliance-building.	0.115
6. Not judging a client gives them a sense of feeling safe.	**0.471**
7. Offering reassurance on confidentiality and boundaries helps a client feel safe.	**0.468**
8. Openness and being genuine on both parts within the relationship support the therapeutic alliance.	0.282
9. A focus on non-verbal communication helps the relationship and process.	0.109
10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.	**0.421**
11. A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.	**0.268**
12. A client who feels powerless can project power onto the therapist.	0.188
13. Being liked by the client helps build rapport and supports the therapeutic work.	**0.432**
14. Intuition tells you the process is working well.	0.195
15. A client needs direction in therapy to help the process.	**0.400**
16. In a brief therapy service, client expectations should be explored, and service provision explained right from the start.	**0.300**
17. A therapist needs to bring their professional and personal self into the relationship	**0.297**
18. Chemistry needs to be present in the relationship to achieve a successful outcome.	**0.346**
19. The longer a therapist works with a client the better the relationship becomes.	0.086
20. A client self-assessment scale could be effective when reflecting own progress.	**0.326**
21. A client does not have to like the therapist as long as they like the work being done.	**0.259**
22. A therapist needs to be mindful of his or her own well-being on performance when offering therapy.	**0.364**

3.3.5 Direct Oblimin Oblique Rotation

Next, the results of the oblique rotation are presented. In an oblique rotation, the resulting rotated factors are correlated, and two different factor-loading matrices are generated: a factor pattern matrix (a matrix of loadings that are like partial standardised regression coefficients (Pett, Lackey, & Sullivan, 2003). These loadings indicate the effect of a given factor on a given item while controlling for other factors), and a factor structure matrix (a matrix of simple correlations of the items with the factors), presented in Table 11 and Table 12, respectively.

As suggested by Tabachnick and Fidell (2007)**,** when undertaking an oblique rotation, the factor structure matrix should be the focus of factor identification and interpretation. Thus, according to the factor structure matrix in Table 12:

- The items significantly loaded on the first factor are: 2, 3, 6, 7, **8,** 11, 16, and 22.
- The items significantly loaded on the second factor are: 4, 10, 13, 15, and 20.
- The items significantly loaded on the third factor are: 17, 18, and 21.

It is almost identical to the results of the varimax rotation, except for item eight. Considering Table 13, the factor correlation matrix (a matrix of intercorrelations among the factors), the correlations between the three factors are weak, suggesting that the factors may not be correlated. Palant (2005) suggests that if the correlations among the factors are low, then the results from the orthogonal rotation (varimax) should be retained, interpreted, and reported. Thus, in this study, the results of the varimax rotation are adopted.

Table 11: *Factor pattern matrix*

	Factor		
	1	2	3
7. Offering reassurance on confidentiality and boundaries helps a client feel safe.	**.680**	-.073	-.101
6. Not judging a client gives them a sense of feeling safe.	**.638**	-.111	.086
22. A therapist needs to be mindful of his or her own well-being on performance when offering therapy.	**.560**	-.151	.002
16. In a brief therapy service, client expectations should be explored, and service provision explained right from the start.	**.559**	.046	-.054
2. Gaining client trust is something that needs working on right from the start.	**.551**	-.109	.041

11. A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.	**.520**	.040	.014
3. In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe.	**.429**	-.333	.084
12. A client who feels powerless can project power onto the therapist.	**.421**	.027	-.199
8. Openness and being genuine on both parts within the relationship support the therapeutic alliance.	.353	-.119	.290
9. A focus on non-verbal communication helps the relationship and process.	.291	-.052	.085
4. A basic structure with general questions in the first session helps a client feel at ease.	.082	**-.659**	-.164
15. A client needs direction in therapy to help the process.	-.017	**-.625**	.051
10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.	.123	**-.617**	-.001
13. Being liked by the client helps build rapport and supports the therapeutic work.	-.021	**-.568**	.263
20. A client self-assessment scale could be effective when reflecting own progress.	.143	**-.526**	.016
18. Chemistry needs to be present in the relationship to achieve a successful outcome.	-.097	-.046	**.589**
21. A client does not have to like the therapist as long as they like the work being done.	.179	.198	**-.446**
17. A therapist needs to bring their professional and personal self into the relationship.	.263	.048	**.444**
14. Intuition tells you the process is working well.	.217	.128	.359
19. The longer a therapist works with a client the better the relationship becomes.	-.020	-.017	.293
1. The therapeutic alliance starts when the first contact is made with the client.	.028	.020	-.262
5. Formal assessment of need in the first session is not important in alliance-building.	.205	.152	.235

Table 12: *Factor structure matrix*

	Factor		
	1	2	3
7. Offering reassurance on confidentiality and boundaries helps a client feel safe.	**.675**	-.168	.025
6. Not judging a client gives them a sense of feeling safe.	**.670**	-.228	.210
22. A therapist needs to be mindful of his or her own well-being on performance when offering therapy.	**.585**	-.243	.120
2. Gaining client trust is something that needs working on right from the start.	**.575**	-.205	.151
16. In a brief therapy service, client expectations should be explored, and service provision explained right from the start.	**.542**	-.037	.033
11. A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.	**.516**	-.047	.096
3. In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe.	**.498**	-.417	.208
8. Openness and being genuine on both parts within the relationship support the therapeutic alliance.	**.421**	-.222	.368

12. A client who feels powerless can project power onto the therapist.	.383	-.011	-.132
9. A focus on non-verbal communication helps the relationship and process.	.314	-.112	.142
4. A basic structure with general questions in the first session helps a client feel at ease.	.162	**-.647**	-.049
10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.	.224	**-.637**	.115
15. A client needs direction in therapy to help the process.	.093	**-.630**	.145
13. Being liked by the client helps build rapport and supports the therapeutic work.	.116	**-.605**	.347
20. A client self-assessment scale could be effective when reflecting own progress.	.232	**-.552**	.122
18. Chemistry needs to be present in the relationship to achieve a successful outcome.	.010	-.121	**.580**
17. A therapist needs to bring their professional and personal self into the relationship.	.330	-.064	**.480**
21. A client does not have to like the therapist as long as they like the work being done.	.071	.237	**-.446**
14. Intuition tells you the process is working well.	.257	.037	.376
19. The longer a therapist works with a client the better the relationship becomes.	.032	-.059	.292
1. The therapeutic alliance starts when the first contact is made with the client.	-.019	.056	-.260
5. Formal assessment of need in the first session is not important in alliance-building.	.220	.082	.246

Table 13: *Factor correlation matrix*

Factor	1	2	3
1	1.000	-0.164	0.168
2	-0.164	1.000	-0.154
3	0.168	-0.154	1.000

The purpose of the EFA analyses in this study was to identify groups of variables (individual items) that covary with one another that appear to define meaning of underlying latent variables (Matsunga, 2010). According to the results of the varimax rotation and factor item groups, three factors are identified which reflect: Factor 1: Relationship-building, Factor 2: Managing the process, and Factor 3: Relational bond - relationship between client and therapist.

- The items significantly loaded on the first factor (relationship building) are: 2, 3, 6, 7, 11, 16, and 22.
- The items significantly loaded on the second factor (managing the process) are: 4, 10, 13, 15, and 20.
- The items significantly loaded on the third factor (relational bond) are: 17, 18, and 21.

3.3.6 Exploratory Factor Analysis Results: Q23-27

The second EFA analysis was performed on the five subsequent survey questions Q23-27, which were scored like the first 22 items on a five-point Likert-type scale from 'Strongly Disagree' to 'Strongly Agree'.

> Q23. In training, a reflective TA process measure on factors identified could heighten trainee awareness on the therapeutic process.
> Q24. In practice, a reflective TA process measure on factors identified could heighten therapist and trainee awareness on therapeutic process.
> Q25. In clinical supervision, a reflective TA process measure on factors identified could heighten supervisor and supervisee awareness on therapeutic process and skills.
> Q26. In my practice, a reflective TA focus measure on factors identified could help evidence how successful outcomes are achieved.
> Q27. A TA measure is not necessary in therapeutic practice.

The first three questions (Q23-Q25) relate to the second research question (What does a sample of therapists think about the potential for a new measure to assist them in awareness of the therapeutic alliance?). The next question, Q26, asks the same question for use in the therapists' own practice. Loadings were highly significant in all four areas. However, the final question, Q27, in this analysis, which asked whether participants agreed or disagreed to whether a TA measure was necessary in therapeutic practice, included in order to not present any bias towards the use of TA measures. In the varimax rotation (Table 16) Q27 loaded negatively. This is also shown in the common factor estimate (Table 17) sharing just 1% of the variance with the four other high loading factors.

In the above instance, it should be noted than an item with a low commonality as in the case of Q27 does not mean a 'poor fit' with other items, but that this item is measuring something different than the other items in the commonality space. For example, failure to load by any of the factors could be indicative of a poor item design, such as ambiguous wording or inappropriate inclusion or because it may not be part of the same domain of interest (Fabrigar & Wegener, 2012). Therefore it is important to be aware that the results on Q27 do not infer that participants in the survey believe a TA measure is necessary in therapy. In fact on reflection of Q27's use in the scale, it might have

been better to have reverse-scored the item, which would still have given participants the option to either agree or disagree accordingly.

These findings have shown that participants highly favoured the use of the TA measurement scale factors in training, practice, and clinical supervision. Further Confirmatory Factor Analysis, is required to refine items, reverse-score, or even drop them accordingly to test reliability and the validity of the new scale. In this study EFA was used as an early stage of investigation for consolidating variables and for generating hypotheses about underlying processes of the TA. Confirmatory Factor Analysis is a much more sophisticated technique in the advanced stages of the research to test a theory on the latent processes (Tabachnick & Fidell, 2001). The statistical analyses are displayed below.

Table 14 shows the frequency counts and percentages of responses of Q23-Q27. Mean, standard deviation, and mode are also displayed.

Table 14: *Frequency counts and percentages of responses: Q23-Q27*

	Frequency counts and percentages of responses						
Survey question	1	2	3	4	5	Mean (SD)	Mode
23	1(1)	4(4)	23(25)	57(63)	6(7)	3.69(0.71)	4
24	1(1)	6(7)	24(26)	56(62)	4(4)	3.62(0.73)	4
25	1(1)	3(3)	23(25)	59(65)	5(6)	3.70(0.68)	4
26	2(2)	12(13)	31(34)	43(47)	3(3)	3.36(0.84)	4
27	4(4)	11(12)	40(44)	29(32)	7(8)	3.26(0.93)	3

Using the following setting, number of variables = 5, number of subjects = 91, and number of replications = 100, the results of the parallel analysis indicate that one factor should be retained. The results of the parallel analysis are displayed in Table 15. The scree plot is displayed in Figure 6. (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree.) Numbers in parentheses under frequency counts are percentages. SD = standard deviation.

Table 15: *Monte Carlo Parallel Analysis output: Q23-Q27*

Eigenvalue number	Random Eigenvalues	Standard Deviation	Actual Eigenvalues	Eigenvalues for Extraction
1	1.286	0.061	3.325	Retain
2	1.145	0.058	0.917	Reject

Table 15 shows that only one factor is retained from the parallel analysis.

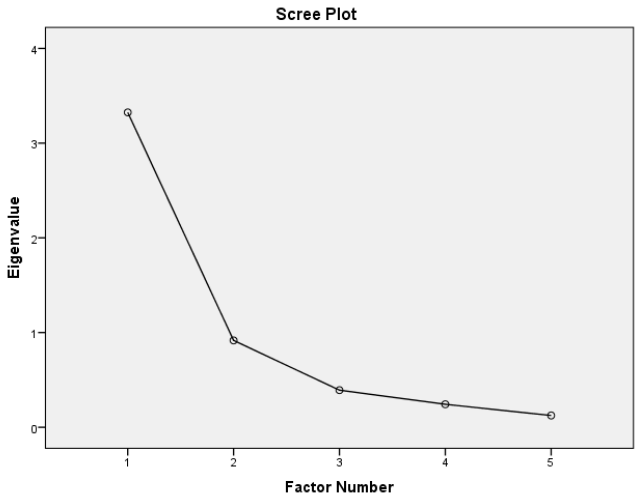

Figure 5: Scree plot, Q23-Q27. The elbow break suggested that one factor should be extracted, as it is where the plot abruptly levels out.

As there is only one factor extracted, factor rotation is not needed. Table 16 shows the factor loadings for the factor. In this study, 0.40 was the cut-off value, and the items significantly loaded on the factor are: 23, 24, 25, and 26.

Table 16: *Factor loadings: Subsets that significantly loaded on the factor are shown in bold.*

	Factor 1
24. In practice, a reflective TA process measure, constructed from factors identified, could heighten therapist and trainee awareness on therapeutic process.	**.947**
23. In training, a reflective TA process measure, constructed from factors identified, could heighten awareness on therapeutic process.	**.920**
25. In clinical supervision, a reflective TA process measure, constructed from factors identified, could heighten supervisor/supervisee awareness on therapeutic process and skills.	**.784**
26. In my practice, a reflective TA process measure, constructed from factors identified, could help evidence how successful outcomes are achieved.	**.763**
27. A therapeutic alliance measure is not necessary in therapeutic practice.	-.331

The Kaiser's MSA = .814 and Bartlett's test of sphericity was significant (p = 0.000), indicating this common factor model is appropriate.

Table 17 shows the final communality estimates. The communality estimates for the five measures (items) represent the proportion of variance of each of the five measures shared by all remaining measures. Like data obtained in Table 10, the same principles apply. The communalities are the estimated proportion of the variance of the variables that contributed to the common factors (common factors = 3), meaning the proportion

of each variable's variance that can be explained by the common factors. In this example, the communality estimate for Q27 is 0.110, which means that only 11% of the variance of the measure Q27 is shared by all other measures. Or put another way, 11% of the variance of the measure Q27 can be explained by the three common factors, which indicates that this measure, to some extent, is a different construct than the other measures. Taking into account that variables with high values are well represented in the common factor space, while variables with low values are not well represented, a small communality estimate might indicate that the variable may need to be modified or even dropped.

The sum of all communality estimates (3.05) is the estimate of the common variance among all five measures. This estimate of the common variance contributes about 61% (3.05/5 = 0.61) of the total variance present among all five measures.

Table 17: *Final communality estimate: Q23-Q27. Total = 3.05 = Sum of the final communality estimates. Items not highlighted were considered to have small communality estimates.*

	Final communality estimate
24. In practice, a reflective TA process measure, constructed from factors identified, could heighten therapist and trainee awareness on therapeutic process.	**0.847**
23. In training, a reflective TA process measure, constructed from factors identified, could heighten awareness on therapeutic process.	**0.896**
25. In clinical supervision, a reflective TA process measure, constructed from factors identified, could heighten supervisor/supervisee awareness on therapeutic process and skills.	**0.614**
26. In my practice, a reflective TA process measure, constructed from factors identified, could help evidence how successful outcomes are achieved.	**0.583**
27. A therapeutic alliance measure is not necessary in therapeutic practice.	0.110

3.3.7 Reliability

Cronbach Alpha was calculated for reliability and internal consistency (Barker, Pistrang, & Elliott, 1994) on the three factor constructs (relationship-building, managing process, and relational bond) identified in the EFA and development of the new TA measure. Table 18 shows the 15 items on the proposed measure that significantly loaded on Factors, 1, 2, and 3. Results for each of the three factors are shown separately in

Table 18, 19, 20 and 21 respectively, Tables 18, 19 and 20 show an acceptable level of reliability above 0.70 (Tavakol & Dennick, 2011). Table 21 however, shows a negative alpha. Tavakol and Dennick (2011) suggest low alpha could be due to the low numbers in the test or poor correlations. However, they also posit that a high alpha 0.90 and above, does not necessarily mean a high degree of internal consistency because alpha also depends on the length of the test (measure). Tavakol and Dennick (2011) also suggest that if the standardised items are higher than the Cronbach alpha, this may mean the "tau equivalent model' which assumes that each test item measures the same latent trait on the same scale" (p.54), would need to be re-examined. However in the results below, you will see there is little statistical difference in each of the Tables.

Table 18: *Cronbach Alpha for Factors 1, 2, and 3*

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.722	.751	15

Table 18 shows Cronbach Alpha's for Q2 Q3 Q4 Q6 Q7 Q10 Q11 Q13 Q15 Q16 Q17 Q18 Q20 Q21 Q22.

Table 19: *Cronbach Alpha for Factor 1: Relationship Building*

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.783	.785	7

Table 19, shows Cronbach Alpha's for Q2 Q3 Q6 Q7 Q11 Q16 Q22.

Table 20: *Cronbach Alpha for Factor 2: Managing Process*

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.752	.753	5

Table 20, shows Cronbach Alpha's for Q4 Q10 Q13 Q15 Q20.

Table 21: *Cronbach Alpha for Factor 3: Relational Bond*

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
-.399	-.401	3

Table 21, shows Cronbach Alpha's for Q17 Q18 Q21.
The value is negative, possibly due to a negative average covariance among items.
This violates reliability model assumptions.

The results from all EFA analyses with subsequent validity-testing of the items for the new measure (Robson, 2011) will be discussed in more detail in Chapter 4: Discussion.

Chapter 4: Discussion

4.1 Study Overview

Over the years there have been many definitions of the TA written through its conceptualisation and re-conceptualisation as more understanding takes place through theories and empirical studies. Several of these definitions are relayed in the literature review at the beginning of this study. Generally, it seems the TA can be defined as a collaborative engagement that seems interdependent upon many positive or negative characteristics (Ackerman & Hilsenroth, 2001, 2003) of the client and therapist, which affects the process of working towards agreed goals and a positive outcome.

The therapeutic experience is different with each client (Cooper & Mcleod, 2011). This suggests in practice, a situation is always a unique encounter within the therapeutic dyad, which suggests the therapist can perpetually evolve and grow (Mearns & Cooper, 2009).

To date, a lot of uncertainty exists regarding the TA because it seems to be a complex phenomenon. Proposed factor structures in TA studies discussed in the literature review have shown the TA to have different, yet overlapping constructs (Cerceo et al., 2001; Elvins & Green, 2008). These factor structures have generally related to task or attachment elements on the TA. In each model, categories are descriptively defined, at the discretion of the author.

This study aimed to unravel some of the mysteries attached to the TA by exploring practising therapists' views on what factors are involved and the factor structure which helps develop and maintain the TA and how the TA could be measured. The study has also addressed whether a new TA measure could heighten therapists' awareness in training, practice, and clinical supervision.

To answer research question one (What are the perceived components and factor structures in therapeutic alliance measurement?), as reflexive practitioners and proponents of future TA literature, participants helped generate factors through the findings identified from a focus group, a panel of judges, online survey respondents, and exploratory factor analyses (EFA) of survey results. A qualitative and quantitative methodology was employed. To answer research question two (What does a sample of therapists think about the potential for a new measure to assist them in awareness of the therapeutic alliance?), first of all, the qualitative data results from the focus group transcript and analysis of the panel judges' findings indicated there are many relational and ethical factors involved in the TA (see transcript and node listings in the appendices). Subsequently, analysis from survey respondents attributed to the final 22 survey items and construction of the new TA measure.

To further support the answer to research question two, the survey responses on the 22 items resulted in a three-factor structure. Items that loaded most significantly in the three-factor analysis identified underlying latent constructs attributed to the TA. In order of significance, factors were labelled as: relationship-building (Factor 1), managing process (Factor 2), and relational bond (Factor 3). It was interesting to note that items in Factor 3 had less bearing on the TA than those in relationship-building and managing the process. This shows an emphasis on task-related elements of the TA and on therapists' skills in relation to how, what, and when ethical and relational factors are enveloped into the therapeutic relationship. Under the three main factor headings it is also clear all factors are pivotal to developing and maintaining the TA. The evidence found in this research suggested the new TA measure (following further confirmatory analysis) could be a useful tool to add to the therapists' toolkit, and could be utilised throughout the duration of the therapeutic process as an adjunct to therapists' reflective and reflexive ethics on best practice.

To help orientate the reader and put in perspective the contributions made to this study, the discussion begins with participant demography. The discussion reflects on the research methodology, starting with the manual and computer analysis which together from the Qualitative Content Analysis (QCA) led to the quantitative design performed through the Exploratory Factor Analysis EFA. The qualitative phase of the research allowed for a deeper engagement with the findings through the transcript analysis reflecting on quotes from participants (displayed in Chapter 3). Subsequently, analyses and the newly identified factor structure attributed to the TA and TA measurement generated through the quantitative phase are each evaluated. From the findings of this study, the discussion subsequently reflected on the implications on TA practice with considerations given to the measurability of the TA from a quantitative perspective. Both have implications in training, practice and clinical supervision. The study's strengths and limitations are presented, with concluding comments for future research inquiry.

4.2 Participant Demographics

A total of 109 participants (therapists, including 18 trainees) took part in the three phases of the study. To help appreciate the demography and breadth of experience of participants, details are presented in Tables 1, 2, and 4. Actual data are presented for the focus group which included seven participants (Table 1) F: N: =7 M: N: = 0. Panel Judges included 11 participants, F: N = 6 M: N = 5 (Table 2).

Descriptive statistics were performed on survey participants presenting one-way frequencies and percentages, displayed in Table 4. F: N= 89%, M: N= 11%. Age ranges were from 18-61+: 18-30 = 8%; 31-40 = 22%; 41-50 = 24%; 51-60 = 30%; 61+ = 15%.

To demonstrate the amount of clinical (real-time) practice undertaken by participants, it is highly relevant to raise attention to the demographic information detailed below, which highlights the breadth of experience attributed to the research findings.

Current qualifications ranged from Diploma level to PhD: Diploma = 47%, Doctorate in Psychology (PsychD) = 29%, PhD =15%, and Masters Degree = 9%. Participants were asked to state their main therapeutic approach. The majority stated Person-Centred/Humanistic = 31% followed by Integrative = 21%, Cognitive Behavioural

Therapy (CBT) = 19%, Psychodynamic 12%, Existential =3%, Psychoanalytical 3%, Systemic = 1% and Brief Solution Focused = 1%. The remainder of approaches were described as 'Other' = 9%, such as Relational or Third Wave. More than half of the participants described their job title as Counsellor = 51%, and the remainder as Psychologists = 14%, Psychotherapists = 14% and Trainees = 18%.

In most professional therapist training programmes, to become a qualified therapist, the number of required therapeutic hours can range from 250 for Diploma level training to 450 for Doctorate in Psychology programmes. In this study, the average years qualified was 6.42 with standard deviation = 6.84 (Fig.1). The above estimates suggest an average of 350 hours per therapist multiplied by the number of qualified therapists who participated, not including pre-qualification hours, six years of post-qualification hours, plus the likelihood that some therapists may do more clinical hours per week each year than others. Trainees' who participated in the online survey would each have accrued clinical hours as part of their training and because of which, were eligible to participate in this study due to their experience with clients and the TA. This gives the reader an insight into the multiple perspectives on therapeutic work with clients, which contributed to the richness of the findings.

The involvement of both qualified therapists and trainees required each participant to take a reflective perspective on their previous and current practice and with thoughts for future practice. Reflective practice is an important part of Counselling Psychology ethical practice (Strawbridge & Woolfe, 2010).

4.3 The Qualitative Perspective

The transcribed focus group interview lasted just under one hour within which many ideas were raised on the interpersonal aspects of the TA believed to help develop and maintain the therapeutic relationship. Robson (2011) proposes there are several advantages for using a focus group in qualitative data collection. For example:

- The amount of data obtained from a focus group is increased because it is collected from several people at the same time;
- Group dynamics help focus on the topic in question making it easy to see where views are shared;
- Participants are empowered to use their own words while simultaneously stimulated by the contributions of others in the group.

Each participant in the focus group was able to reflect and draw upon their respective therapeutic encounters and it soon became evident that a confluence of minds and mutual respect had emerged. This allowed for insight into the position that both therapists and clients find themselves in many aspects of the therapeutic context. For example, participants offered several definitions of the TA along with 'explicit' and 'implicit' practises, both felt to be important to sustain the TA and therapeutic relationship. Teyber and Holmes McClure (2011) discuss these two levels of communication as 'process dimension'—a point from which different levels of communication occur simultaneously that distinguish between the overtly spoken content (explicit) and how the client and therapist interact (implicit).

In the identification of factors attributed to the TA, Person-Centred (Roger, 1951), Cognitive Behavioural Therapy (CBT) (Beck, 1976), and Psychodynamic (Jacobs, 2004) approaches are apparent as each of these theory-based therapies represent both explicit and implicit levels of communication. Historically these approaches are considered core to Counselling Psychology because involving the three can increase the client's capacity for self-determination (Strawbridge & Woolfe, 2003). Each approach will be discussed at different points throughout the discussion.

To avoid any personal bias and *a priori* effect on the researcher's part (as the sole analyst), careful consideration was given in choosing which quotes from the focus group transcript would best attribute knowledge and understanding on how to develop and maintain the TA. In doing so, it is hoped this provided the clearest explanations from the perspectives of the participants. The procedures are stated in sections 2.3.1, 2.3.7 and 3.2. In addition, the researcher was mindful of some further important issues when selecting items for TA measurement. For example:

1) Drawing from phenomenological psychology, the analytical emphasis is on the subjective, idiosyncratic perceptions and motivations of individual participants and is particularly useful when interested in the detailed and in-depth reasons why one person favours an aspect on the TA to be more important over another person

2) Exploration of the complexities and ramifications of the attitude areas in order to decide more precisely what was to be measured (reference to conceptualisation)

3) To get vivid expressions of such attitudes from participants in a form that might make them suitable for use as statements in an attitude scale (relevant to the research questions in providing further understanding on the TA), that is, the statements needed to be meaningful and

interesting (Oppenheim, 1992). Actual dialogue was used as much as possible in constructing coherent statements.

4) The selection of the final items was developed in two stages: 1) the panel judges made judgements by scoring statements, 2) responses from online survey respondents, which along with focus group data led to the construction of the new TA measurement scale. The TA items were considered from an Integrative therapeutic position, which synthesises two or three theoretical approaches as discussed by (O'Brien, 2010).

Collectively, these considerations helped to reduce personal biases or *a priori* effect on the part of the researcher, to ensure items would be relevant and meaningful within therapeutic practice and encourage trainees and therapists to think about their practice reflectively. This would also help them work through the new TA measure, and identify the implications each item has on practice. Two different forms of analysis (manual and computer) supported these efforts providing clearly stated step-by-step analysis procedures which were undertaken within this research design. Five key questions emerged through the qualitative analysis: To recap, these were:

1. What Is The Therapeutic Alliance?
2. When Does The Therapeutic Alliance Start?
3. How Do Therapists Develop The Therapeutic Alliance?
4. How Do Therapists Maintain The Therapeutic Alliance?
5. Is The Therapeutic Alliance Measureable?

On reviewing the results for the manual analysis generated through the transcript and in response to what appeared to be participants questioning what the TA is, the first question which emerged under the heading, "What Is the Therapeutic Alliance?" section 3.1.2, showed from these accounts, that the TA appears to represent a middle ground (the work or space) something shared between client and therapist, which could be viewed as more task-related. In the fourth example (line 17) this participant initially refers to the experiencing of the TA (referring to chemistry and atmosphere between client and therapist) which may infer this to be implicit and more attachment bond-related. On the other hand, the participant also suggests a conscious effort on how the TA is maintained as it refers to the task on how therapists facilitate the core conditions described by Rogers (1957).

O'Brien (2010) distinguishes two facets of the TA, 'being with the client' and 'doing'. In the first component 'being with the client' is a shared experience, which describes the

TA as developing a productive collaborative relationship. O'Brien claims this component emphasises the client's active participation and engagement in supporting therapeutic outcome. Whereas a 'doing' component is where the therapist's 'task' when forging the TA is to make contributions that can help facilitate and promote collaboration. O'Brien (2010) posits the therapist can move between the 'doing' (tasks of therapy) to the 'being with the client' aspect of therapy (the shared private experience) because both are concurrent phenomena, and this can be something observable. "Epistemologically, although the alliance may be understood as partly observable, it is usually considered as residing substantially within the private experience of the participants" (Muran & Barber, 2010, p. 45) suggesting the TA may be predominantly unobservable.

Many factors were observed in both the manual and computer analysis that account for O'Brien's, and Muran and Barber's perspectives. For example, in the 'doing' component factors included 'managing challenges' and 'structuring the process' whereas the 'being with the client' component relates to 'beliefs in the client's ability' and 'implicit communication'. O'Brien (2010) suggests the TA is like a bridge between 'doing' and 'being' in pursuit of therapy goals.

Teyber and Holmes McClure (2011) suggest that the TA is akin to Bowlby's description of a 'holding environment' in attachment terms. This means the client's emotional distress is 'held' or contained in the safety of the relationship and the therapist's understanding. According to Bowlby's concept from O'Brien's perspective, the shared experiences of the emotion are 'being with the client', whereas consciously holding the client's distress within the relationship would be a 'doing' or task aspect.

These accounts show different definitions of the TA (described as 'middle ground', 'chemistry' and 'atmosphere', a 'process dimension', something 'partly observable', and a 'holding environment') suggests the TA has different meanings for different people. This seems to mean the TA, as an entity in therapy, is something subjective and held within the individual's repertoire.

When reflecting upon the second question under the heading, "When Does the TA start?" studies have not only shown the importance of early TA development

(Constantino, Castonguay, &, Schut, 2002; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006), but disengagement of therapy is also linked to the quality of the TA (Roos & Werbart, 2013).

The specific point at which the TA starts to develop seems to be less known, yet interestingly, an issue that was raised in the focus group discussion when reviewing the therapeutic process led to how therapists can have contact prior to therapy through website advertising and mobile networking. Some participants referred to the importance of the TA by what takes place before therapy actually begins, which was based on 'client pre-therapy expectations'. This factor was identified as a factor in the manual analysis of the transcript, yet not detected through the computer output and highlighted the importance in performing the two qualitative analyses.

A client's culture, ethnicity, age, and gender will naturally mean they have different expectations of their therapist (Haugh & Paul, 2008). As suggested by one participant, in the stage prior to therapy, potential clients may be looking for something that resonates within themselves (section 3.1.3 "When Does the Therapeutic Alliance Start?" (line 91). This might be through something written or perhaps even the photograph of the therapist that fits his or her own needs.

Participants' quotes documented in section 3.1.3 highlighted some advantages for clients on researching potential therapists on the Internet and how this helps therapists in terms of 'fit' (line 98). Thus when the TA starts could be influenced for some clients by what type of service the client receives (paying or non-paying) and even before actual face-to-face contact is made (line 107).

As a case in point, for many therapists working in non-paying services such as the NHS, the chance to communicate with their clients until the first session may not always be possible. In this instance, one participant suggested the TA starts right at the first point of contact (line 109). This was elaborated on by another participant in the private sector who suggested that the advantage of clients having some insight into their therapist (through website advertising) could help reduce a client's anxieties attributed to seeing a new therapist (lines 113, 115-118) as opposed to those who are unable to explore information on their therapist before sessions begin.

When the TA starts, regarding 'client pre-therapy expectations' was highlighted in a study on pre-treatment expectations for substance abuse clients embarking on a Cognitive Behavioural Therapy programme. In this study, authors suggested client expectations lay the foundations for the TA because the client will have expectations of the therapist's ability to implement change (Kuusisto, Knuuttila, & Saarnio, 2011). Muran and Barber (2010) also acknowledge the influence of clients' expectations and report that clients' positive expectations on improvement can expand the TA and overall outcome in therapy.

The quote from a participant when discussing advantages of Internet information for both clients and themselves, states this is "useful in terms of fit" (line 98), suggests something 'intersubjective' (Stevens, 2002) and something that may link the client and therapist quite early on, even prior to therapy. Moreover, these opinions suggest the TA could start sooner than suggested by some empirical arguments put forward on early TA development, including suggestions the TA starts around the third session. (see Muran and Barber (2010), Chapter Three, pp. 52-54 for a discussion on several views). Although this type of link might appear implicit, Stevens (2002) refers to intersubjectivity or 'assumptions of consciousness', as an understanding of the 'self' in others. Put more simply, Stevens (2002) suggests the therapist becomes aware of the client's needs through an awareness of their own needs, for example, recognising similar qualities, traits, likes and dislikes etc and links this with what the client is aware of in them to support engagement.

Client pre-therapy expectations, such as those described in the above quotes, may also be linked to unconscious processes of transference and countertransference prevalent in 'psychodynamic theory' (Jacobs, 2004) briefly described earlier (p.20), where a client transfers his or her feelings that historically belong to some other relationship onto the current relationship with the therapist (transference) and vice versa (countertransference). If positive transference, or rapport, which Freud referred to as the 'unobjectionable positive transference' (Muran & Barber, 2010) is not established this will make the development of the TA harder to set up between client and therapist (Spurling, 2004).

Psychodynamic theory makes claims that a child's past experiences are assumed to cause their current behaviours (Proctor, 2002). Therefore, when considering when the TA starts or starts developing, from the psychodynamic perspective, a psychodynamic therapist listens for conscious and unconscious thoughts and feelings, meaning what the client is aware of and what they are not (Frederickson, 1999).

The above accounts on pre-therapy expectations from the standpoint of intersubjectivty (Stevens, 2002) and psychodynamic approach (Jacobs, 2004; Frederickson, 1999; Proctor, 2002; Spurling, 2004) help raise a key point on the importance that therapists prepare for new clients pre-therapy, not only practically but psychologically as much as is reasonably practical to do so. This could mean the therapeutic relationship and commencement of the TA could become a more manageable process for therapists in engagement, retention, and dropout rates and could enhance skills in building and repairing the relationship (Roos & Werbart, 2013).

When considering further, the development of the TA, in therapeutic work (the third question, under the heading, "How do therapists develop the TA?" (section 3.1.4) this was explained on the basis of the phenomenological perspective, discussed by Corrie (2010). "...The search for knowledge must always begin with a desire to understand our clients' stories" (Corrie, 2010, p. 57). This position refers to the 'phenomenological approach', which is the study of human awareness as we experience it. "It is called phenomenological because it deals directly with phenomena, i.e. that which we are of" (Stevens, 2002, p. 150). This is linked with earlier discussions on intersubjectivity. This awareness may be particularly important at the exploratory stages of therapy, such as in the assessment or first session, to support the TA and the client and therapist in building rapport. Empathic understanding of the client on the therapist's part is considered universal in successful outcomes. Over the last two decades there has been less emphasis on rapport and empathic communication between client and therapist (despite previous studies showing that high levels result in positive outcomes) (Haugh & Paul, 2008), outcomes now linked to the TA although there does seem to be a shift in thinking regarding relational factors (Ackerman & Hilsenroth, 2003).

In the early development of the TA, factors identified in this study seem predominantly relational situated in the attachment bond, reflecting Bordin's (1979) working alliance model. In particular, as shown in the transcript (see appendices), developing the TA appeared to be therapist-driven based on these relational factors. Much reference was given to the ethical position of therapists within therapy and included what, how, and when these are applied in therapy.

Participants felt united on each of the ethical factors that pertained to ethical practice in developing the TA. These factors were attributed to the client's personal growth. In the NVivo 10 transcript analysis the 'tag clouds' (appendices 16 and 17) show the frequency of word use. These highlight that the most used words were 'MMs' and 'Yeahs', which reflect a lot of agreement among participants on the topics discussed.

Many of the participants' views on ethics, such as facilitating autonomy, empowering clients, their beliefs in the client's ability, and being open and genuine are all acknowledged as factors attributed to the TA. These are factors that reflect the person-centred approach (Rogers, 1951). The person-centred approach derives from the humanistic paradigm (McLeod, 2003a) founded on the belief that (given the right conditions) a client can work towards resolutions in their own distress (Rogers, 1957).

Rogers suggests three 'core conditions' for human growth are necessary for therapeutic change. These are 'empathy', 'congruence', and 'unconditional positive regard' (Roger, 1957). According to Rogers (1957) if the core conditions were experienced between the client and therapist within the therapeutic setting this would help a client to move on in their lives. Rogers put a great deal of emphasis on the therapist's ability to make change. These elements were recognised as highly relevant factors by focus group participants in TA development. Person-centred theory emphasises the importance of a client's 'organismic self' (the first valuing process, which reflects the 'actualising tendency'—described as the single basic motivating drive). This means a position where we do what comes naturally, which can lead to the 'actualizing tendency' (Rogers, 1963). This concept describes the human urge to grow and reach our maximum potential (Rogers, 1957) and the standpoint that reflects the many quotes from participants in developing and maintaining the TA. The central hypothesis of the person-centred counselling approach is that every person has, within themselves, vast

resources for self-understanding that can alter a client's self-concept, attitudes, and behaviour (Rogers, 1957). These matters are also explored under the third question and heading, "How do therapists develop the TA?" (section 3.1.4). For example, this highlighted the importance of respecting the client (line 1) but also respecting the work (line 2), by providing structure to help maintain the boundaries on safety (line 152). Thus offering comfort and helping the client feel at ease by providing a safe environment (line 209) by being accepting of the client (non-judgemental) (line 225), allows the therapist to become attuned to the client's needs, while working within an ethical framework (line 248). This subsequently helps to facilitate the client's sense of self (line 365) and demonstrates how these interventions (by the therapist) can help with relationship building in early sessions and can generate a feeling of potential in the TA process (line 589).

The factors identified from the transcript manual analysis and NVivo computer analysis (see appendices) collectively reflected many TA elements associated with Bordin's (1979) working alliance (TA) model. In the manual transcript meanings are recorded alongside clusters of quotes. Coding is never exhaustive because any coding process is not a precise science, but an interpretative act on the part of the researcher (Saldaña, 2009).

The NVivo 10 computer analysis in total comprised 79 coding reports, which included a variation of factors that were coded under the heading 'Factors' (see node listing in the appendices). Categories in the computer analysis were named under three main headings: one main heading (Bordin) and three subheadings (attachment bond, shared goals, and tasks) and two further main headings (Factors and Measurement) which all seemed to fit the TA concept in generating factors from each category. This was not surprising because in the computer analysis, as stated above, 'Bordin' was one of the main categories entered into the computer analysis coding process.

Reference to the statements given in the quotes from participants (section 3.1.4) suggest that in developing the TA some therapists value the 'attachment bond' aspects of the TA through the general TA factor 'therapeutic relationship' (Bordin, 1979) to support the work and outcome. Some therapists may even view early development of the TA similarly to the qualities of a friendship (suggested by participant 1 who seemed to feel

the need to be liked to support the work (section 3.1.4 - line 1). This standpoint supports a study by Muran (1993) who found friendliness between client and therapist is positively rated in regards to the quality of the TA. On the other hand, other therapists may put more focus on the 'work itself' (described by participant two (line 2) in developing the TA, as emphasised in TA literature by Sterba (1934) and Greenson (1967) and later studies by Gaston (1990) and Hougard (1994).

To this end, the above section and quotes provided that support the development of the TA has shown that when developing the TA this can take different forms, such as friend, facilitator, or guide in the exploratory stages of therapy.

The fourth question, which emerged, and comes under the heading, "How do therapists maintain the TA?" (section 3.1.5), can be even more complex because, as well as applying relational skills like empathy, unconditional positive regard, and congruence, they also need to focus on relational interpretations or repairing ruptures (Cooper, 2008). Therapists also need to demonstrate techniques or technical factors which are about what therapists 'do' and are "procedural rather than competency-based, designed to bring about particular responses or outcomes" (Cooper, 2008, p. 127).

However, there is growing evidence that relational factors from clients' perspectives seem to favour the 'nontechnological' (relational) factors, such as being listened to, being understood, or just having someone who can offer an external perspective (Cooper, 2008; Strawbridge & Woolfe, 2010).

Even though relational factors may tend to lean towards relational therapies like the person-centred approach, CBT studies have shown that clients found their relationship with the therapist more helpful than the CBT techniques (Cooper, 2008). The advantages of Bordin's (1979) TA model "is that it highlights the interdependence of technical and relational factors" (Safran & Muran, 2006, p. 288). This means the model focuses on the client's uniqueness as a function of his or her own development and sidesteps whether the TA is conscious or unconscious (Safran & Muran, 2006). At a time when the jury is still out on whether therapeutic orientation (which can focus on either conscious or unconscious processes) outweighs relational factors or vice versa on outcomes, (for example, in CBT where techniques predominate) this might explain why

Bordin's model has become particularly influential among therapist researchers (Safran & Muran, 2006).

This CBT process relies upon the client being able to work through certain tasks learned in therapy so that they can be practised between sessions. CBT is a contractual therapy (Salkovskis & Clark, 1998), although CBT requires homework, inventories, form filling, etc., which suggest intellectual ability. Beck, Rush, Shaw and Emery (1979) observe that high intelligence is not required for the client or the therapist. CBT can be adapted by getting rid of jargon and psychobabble (as the authors refer), employing straightforward information and procedures. In recent years research has shown CBT to be effective with a diverse range of clients from different cultural, social, and educational backgrounds (Persons, Burns, & Perloff, 1988). Studies have also identified that CBT can be adapted for older people (Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003), those with learning disabilities (Kroese, Dagman, & Loumidis, 1997), children, and young people (Stallard, 2002).

The importance of the TA in CBT has been highlighted by Castonguay, Constantino, McAleavey and Goldfried (2010). The CBT approach, while being collaborative in agreeing on goals and tasks of therapy, can also mean at times a therapist will need to structure sessions and decide what topic is useful for the client to discuss (Proctor, 2002). This might mean the therapist will need to be ahead of the client in order to guide the work. In this instance, if clients have irrational thinking styles that increase distress, the therapist will facilitate opportunities and the space to help promote client change because these are principles applied in the CBT approach (Beck, 1976).

In further quotes from the transcript, participant two discusses an experience in how they maintained the TA. This discussion is recorded in section 3.1.5 (lines 255, 283,287) where participant two reflects upon their actions (inferring a CBT approach through directing the client) and yet a situation that could have easily caused a rupture in the TA and the therapy itself. For example, in this instance, it was felt by the client, that the therapist (participant two) was ahead of, or rushing the client. Participant one went on to explain how the experience was useful in terms of the client feeling able to be more open in the relationship (line 287) and acknowledged by other participants that this honesty allowed the client autonomy and to be themselves (lines 293,296 and 312).

As a result of the client's ability to be honest with the therapist, directly confronting the therapist with their concerns, a concept known as 'confrontation ruptures', discussed by Safran and Muran (2006), the therapist appropriately addressed and acknowledged the client's honesty, which appeared to have helped strengthen the TA. Conversely, the thought of this type of confrontation led to participant one potentially feeling criticised, if they had received such a response from a client (line 280). However, while participant two admitted they did not feel great, at first, about the remark, when the participant reflected upon it after the confrontation, they felt this turned out to be good because it showed the client could be honest with their therapist.

There has been much reference to the effects therapists can have on clients and the TA (Ackerman & Hilsenroth, 2001; 2003), but therapists will also have expectations. Haugh and Paul (2008) in their book on the therapeutic relationship, claim that therapist expectations are usually based upon their therapeutic style, meaning they will expect their clients to sit down and talk, but according to the client's culture, etc. Haugh and Paul (2008) suggest this may not be so immediate for some clients and the client might stride around the room, which could get a negative reaction from the therapist. However, as found in another experience explained by participant two, who found themselves sat on the floor back to back with their client, this type of 'culture' was managed in a way that maintained and improved the TA. The participant talked about how she and her client sat on the floor with their backs to the wall and did not make eye contact. The participant suggested it was at this stage they believed the TA started working, and other participants reflected the scene and work, acknowledging the need for flexibility within the text book learning of maintaining a therapeutic relationship. See lines 412, 417, 418, 425, 428, 437, 441, 442, 443 for these quotes and responses from other participants in the focus group on this point.

As suggested above in relation to the CBT practice, this approach can be directive (Proctor, 2002) but in the main, the therapist needs to remain 'at the side' of the client to maintain pace and to regularly check that the work is helping the client, which reflects an ethical and ongoing standpoint on obtaining regular informed consent. For example, informed consent might be negotiated at the beginning of therapy but can change over

the course of therapy (Shillito-Clarke, 2010). Therapist need to be mindful of re-visiting consent.

Note that being alongside the client is not the same as being 'on the side' of the client. The latter means the therapist is carrying the weight of the client's difficulties, which can be a dangerous conception about their role (Mearns, 2003). An ethical standpoint that suggests 'being with the client' (O'Brien, 2010) should also be observed because the therapist cannot guarantee they will be able to sustain the client's emotional weight. Neither is there a guarantee that a client might not reverse their thinking from the side the therapist might have previously supported (Mearns, 2003). Being 'on the side of the client' should not be confused with Bowlby's 'holding concept' (Teyber & Holmes McClure, 2011) discussed earlier, which is ethical and maintains boundaries on a therapist's part.

A further example on the need for flexibility and acceptance on the therapist's part on unconditional positive regard (Rogers, 1957) was described by participant two (worthy of reporting especially for trainees learning the core conditions). In this instance, the client felt unable to face the therapist and yet the therapist quite rightly worked with this situation. Although it took a long time, participant two explained the client did eventually face him and subsequently appeared far more relaxed within the process (line 452).

Concluding this section, on how therapists maintain the TA, one participant in the focus group described the therapeutic encounter as 'like a dance' (lines 935-941) and went on to describe the dynamics that can occur in therapy to achieve a successful outcome. This suggests that the power of therapy itself can pull the therapist in different directions. The quote might also infer that dynamics can change dramatically and at times the therapist might find they are guiding the process in a manageable way, but this can quickly change. This reflects a need for the therapist to be astute and prepared for how he or she responds or acts in changeable situations. For example, Lambert (2010) has reported in his book, that positive and negative changes in clients can be affected by therapist actions and inactions. This indicates a great deal of skill and precision is needed on the therapist's part and reinforces the point that a therapist's skills are important to all aspects of the TA: pre-therapy, during the development of therapy, and

throughout the duration of therapy to be able to prevent and overcome ruptures in therapy, which can otherwise create tension or breakdown in the therapeutic relationship (Safran & Muran, 2000).

What is transparent in the above quotes (from the transcript) is the overarching theme on 'Ethics' in terms of respect, protection and yet empowerment of clients. Counselling psychologists, as members of the Division of Counselling Psychology, not only practice under the BPS Code of Ethics and Conduct (2009) as described earlier, but practice under supplementary ethical recommendations (Bond, 2000). These principles are the moral principles of 'Autonomy', 'Beneficence', 'Non-maleficence', 'Justice', and 'Fidelity' described by Shillito-Clarke (2010) and clearly important with therapists.

The accounts from participants on TA measurement are documented in the transcript and in the results section (chapter three) of this study. The excerpts are perceived to be the clearest and fairest examples (viewed by the researcher under methodological conditions discussed earlier) and are examined under the fifth and final question in the qualitative analyses, "Is the TA Measurable?" (section 3.1.6). As a reminder to the reader, these quotes were in response to reflections on the two TA measures (HAQ-II (Luborsky et, al., 1996) and WAI-S (Tracey & Kokotovic, 1989) (section 2.2.8 and scales are shown in appendix 11 and 12), introduced in the focus group as an optional resource to support the participants' understanding of the types of measured components currently assessed in TA measurement.

The examples described in section 3.1.6, show that therapists can see the advantages and disadvantages of TA measurement. In the first excerpt (line 826) inference is given to the changing culture on evidence-based practice. Participants also showed that some therapists are open to the concept of TA measurement and recognise that producing evidence on their practice is becoming a cultural norm and guesswork is something that may soon become unacceptable (Cooper, 2008). However, there also seems to be awareness that obtaining TA data needs a lot more consideration on how measurement is undertaken in terms of, when, where, and by whom, due to human nature effects that can subsequently affect how both clients and therapists rate the TA at any given time. These issues are explained by participants (lines 827-828, 833, 835, 837, 838,839, 903-

908). These quotes conclude the five key questions which emerged from the qualitative analyses.

The following two sections will address the implications on practice from a qualitative and quantitative perspective as shown through the findings in this study.

4.3.1 Implication on Practice – The Qualitative Perspective

Increased emphasis on 'pre-therapy expectations' may seem more feasible in private practice regarding links through media information making clients' tentative connections with private therapists more accessible. Nonetheless, this need not deter any therapist or trainee from assimilating knowledge on pre-therapy expectations in preparing for any client in any service. For example, this type of knowledge could be applied in therapeutic training to help explore the expectations of clients, especially for trainees in early practice. In non-paying therapeutic services such preparation could help develop therapeutic skills in readiness for TA development and promote quality care from inception to the end. This means pre-therapy expectations are a dimension to therapy in the development of TA 'relationship building' and in 'managing the process' that need more pre-treatment consideration, which otherwise, could be overlooked.

The factors that can help develop and maintain the TA have been explored through a blend of idiographic and theoretical standpoints on factors favourable to the concept. The key points of reference that have emerged from the qualitative data in this study, and have implications on practice are summarised below.

- The TA has the potential to start before clients and therapists have face-to-face contact within the therapeutic environment, usually through the medium of Internet access. This provides potential clients with important information when seeking a therapist. This could be conducive to the TA from both perspectives: the client feeling able to engage with the type of therapist they envision and the therapist benefitting through someone who is ready to engage them.
- The TA literature in general and views in this study have made much reference to the development of the TA, early TA advantages, and that ethical practice facilitates this.
- Therapists need to consider and prepare for situations that require acceptance and a non-judgemental attitude towards clients who may not present in the conventional way (sit in the chair face to face with the therapist).

- Demonstrating the 'core conditions' towards clients, described by Carl Rogers (1957) and openness and honesty by therapists can support empowerment, be self-governing for clients, and support developing and maintaining the TA.
- Integration of orientations (therapeutic styles) may help address different aspects of the relationship, which can support the TA in aspects that are observable and unobservable.
- Confronting possible ruptures within the relationship can develop and maintain the TA. Clients should be made aware of their rights on confrontation early on in therapy (during the relationship contracting stage). Therapists should be responsive to clients who confront concerns as this demonstrates ethical obligations and clients' best interests.
- While therapists will apply their own therapeutic style based on their own therapeutic orientation, the ability to recognise that style may sometimes present potential ruptures could be overcome by adopting relational rather than technical aspects of practice.
- Relational factors appear to be receiving more attention in therapy, attributing to a positive TA. This is acknowledged in the literature and reflected in this study.
- TA factors can be observable and unobservable through explicit and implicit communication in therapy.

A summary of the implications on practice in TA measurement as identified in the qualitative analysis are as follows:

- concerns regarding accuracy through client honesty;
- when and who measures the TA;
- whether the TA measurement should be done anonymously so that clients and therapist may not feel intimidated by the process;
- implications that if honest, clients fear of offending the therapist who is trying to help them, which may create breakdown in the therapeutic relationship and even discontinuation of therapy for the client if this made them feel uncomfortable regarding future work;
- lack of client understanding on what was being measured or the inability to articulate or quantify what has actually helped;
- some therapists might feel they are being measured rather than the TA;
- ambiguity over what might have been rated, i.e. how the client was feeling at the time might not have been considered so bad afterwards.

The measurement of psychological interactions (TA) is therefore always going to be complex. Many references to this effect have been made within the literature review and within the data collection of this study which could put pressures on clients and therapists, albeit for many different reasons. Nonetheless, in therapeutic practice, we need as much transparency as possible in practice to protect clients. Increasing calls for evidence-based information on therapy (a benchmark on measurement of the TA as it is currently known to be the best predictor of outcomes) is undoubtedly needed. Whether

TA measurement could be used to a greater or lesser extent, such as when clients are extremely vulnerable or for those with less intense difficulties remains to be seen. Alternatively, TA measurement could be benchmarked across all services through global reliability and validation. As there are many complexities identified with TA measurement, the strength of TA measurement scales may lie in confirming acceptable rather than clinical cut-offs levels of rating (indicated by participants) in a qualitative way, for example, incorporating TA items identified through this study, especially when the TA construct could be impossible to scientifically quantify, for the many reasons raised.

There are many different TA measurement scales used in different settings. If the aim is to obtain regular data from our clients, then it may be in everyone's best interests to use a standardized scale. This means wherever one works the standards on practice do not differ. Another point of reference is that if we continue to measure the TA to a measure that may not be totally measurable, some might give up on measurement because it takes up too much of a therapist's time and at times of extreme busyness as stated in the literature review. Researchers should therefore work towards a happy medium. This means more focus on ranges within identified benchmarked measurements. For example, in body temperature, temperature levels can on average fluctuate up to two degrees in individuals for different reasons. Yet these readings can be considered within the normal range, if the person is not experiencing any physical symptoms. In relation to TA measurement, allowing for some fluctuation due to the uniqueness of each therapeutic encounter, within an acceptable range deemed good practice, ambiguities regarding what is being measured, a change of mind on rating from one session to the next, etc., plus many other variables that can make the TA complex, could then be accounted as evidence. Ultimately, whichever way forward psychotherapy moves, protecting clients and therapists who work on clients' behalf has to be the most paramount pathway for all.

To complement the findings and implications on practice from the qualitative domain, the subsequent section focuses on the results from the EFA and underlying constructs that reflect the factor structure involved in the TA. Procedures for naming factors and

subsequent implications on practice from the quantitative analysis perspective are explained.

4.4 The Quantitative Perspective

The EFA orthogonal rotation identifies the uncorrelated variables that are independent from each other (Field, 2013). To illustrate these differences, a new therapist awareness TA measurement scale would be constructed by bringing together the factors identified by the findings in phase one and two of the research. A new TA measurement scale would explicitly emphasise Factor 1 and Factor 2 (tasks) as relationship-building and managing the process, rather than just naming them or integrating items of both factors as tasks of the TA. In doing this, it will help those in training and practice to distinguish the different dynamics in developing and maintaining the TA. It is envisioned that by understanding these differences, along with the items that make up these factors, TA skills can be more easily learned as representative of good practice in any contexts of psychotherapeutic practice or across interpersonal relationships in service professions.

The naming of latent factors is at the researcher's discretion because they are merely convenient descriptions of variables, a process that involves art as well as science (Tabachnick and Fidell, 2001). Theoretically, in factor analysis, it is suggested that checking at least the top two items of the factor loadings can help support the naming of factors (Pallant, 2005). However, to create a better balance on themes, examples of the top three loadings that were significantly loaded on each of the three factors were considered (section 3.3.4 -Table 9). The implications on practice are discussed from the quantitative perspective, on the EFA findings.

The results in this study showed that within the factor structure, the top items in factor one *(*relationship building) reflected trust and safety, but, the researcher believed further consideration of all items in this factor was still needed to help put into context how all items could best be represented. With this in mind, to support the trainees' awareness in the learning environment on what is required of them within the therapeutic process at different stages, it seemed logical to consider this process as having a beginning, middle and end. In addition, the researcher believed that from a teaching perspective of TA

skills, being able to separate the three different factors (as they emerged in the findings) under the three given general headings, would be beneficial in providing clearer explanations on what responsibilities and interventions were needed at certain times. This would also allow for flexibility (within the three factor structure) according to what is required by an individual's need at any given time across the whole process of change). In this study, it was therefore considered that the components of 'trust' and 'safety' are very much acknowledged in factor one, but both are still facets of relationship building. Thus naming factor one 'relationship building' suggested to the researcher to offer more clarity on this important dimension in therapy in the process of helping to develop and maintain the TA.

Factor two leans strongly towards 'structure' but again, consideration was given to the general term 'managing the process', for this factor. Providing structure in the therapeutic process was envisioned by the researcher as a necessary component, but again, in naming this factor, it was thought more awareness would be gained (from a learning perspective) by trainee therapists, allowing for an increased understanding of their responsibilities in the process of developing and maintaining the TA, indeed, other aspects of their therapeutic work that need managing. Thus for factor two, it was decided that a general category 'managing the process' seemed preferential, because this named factor draws attention to trainees' and therapists' responsibilities on 'structure', which is most certainly, an important aspect of a therapist's responsibilities.

Factor three was easier to name (relational bond) because it instantly reflects the relational bond between client and therapist which is founded on implicit and explicit interpersonal exchanges

For Factor 3, it was decided to call this factor the 'relational bond' because it was felt the term 'relational' interlinked better with relationship elements, which Factor 3 clearly represents. Items 17, 18, and 21 reflect what Muran and Barber (2010) might consider the unobservable factors of the TA. Note that Q21 (Table 9) was negatively significant, indicating this item could have been reverse-scored. Reverse-scoring items can prevent response bias (Pallant, 2005). This will be considered in further analysis testing (beyond this study) on refining items for the new TA measure.

4.4.1 Implications on Practice – The Quantitative Perspective

On naming factors (as explained above) careful consideration was given within the context of teaching and learning, practice, and clinical supervision, moreover, the implications on practice in protecting clients and obtaining evidence on practice. It was therefore decided that to suggest general categories that were explicit in nature, would support the following:

- Teaching and learning TA skills' development and maintenance through the identification of clearly defined categories on the therapeutic process
- Self-reflection on practice.
- Analysis of practice in the supervision process for supervisee and supervisor.

Therefore it was envisioned by the researcher, that through these considerations, teachers, trainees or therapists could more easily identify the type of intervention used under each of the three category factor headings (relationship building, managing the process, and relational bond*)* thus enabling them to explain not only what, or how, they might intervene in practice to enhance the therapeutic experience for clients, but also why. This standpoint fits with Cooper's vision that therapists need to know how to explain their therapeutic procedures and can no longer rely on guesswork when demonstrating evidence in practice (Cooper, 2008).

Collectively the three factors and the items within, are believed to be relevant to the TA from the focus group's perspectives and the panel judges' professional perspectives, (the latter required in the 'Thurstone model' (Oppenheim, 1992) and, are items that achieved the most scored responses from both qualified and trainee therapists across different therapeutic orientations in the survey of items.

For these reasons and because we may still not yet be completely clear about the functionality of the TA, it would have been less conducive in practice to have documented the findings under the umbrella of a one-factor model namely the 'relationship' as in Bordin's (1979) model, even though definitions within Bordn's model are highly popular (Safran & Muran, 2006).

Precision on factor names was also considered highly relevant to future practice despite the fact Elvins and Green (2008) remind us that generalities may be necessary when considering the TA. For example, we have been accustomed to models, which refer to personal-alliance or task-alliance described earlier. Being more specific regarding TA content and functionality is important and necessary to help raise attention and profile therapists' responsibilities and contributions in therapy to safeguard clients, which could be crucial to development within an expanding evidence-based culture.

4.5 Conclusion

This study has shown that participants as practising therapists were united on the many ethical, task-driven, and relational factors attributed to developing and maintaining the TA. A new TA measure was produced to ascertain best practice as viewed by therapists and one that could assist the whole therapeutic process. The new measure (through EFA) identified a three component factor structure, comprising two 'task-related' factors, and one relational-related factor, as a new theoretical model of the TA. Overall, participants agreed that a new TA measure constructed through this research, incorporating factors identified in the data analyses, could heighten therapists' awareness and assist in training, practice, and clinical supervision. Through use of key factors incorporated in the context of a simplistic therapeutic tool, many elements of practice can be considered, such as:

- within a learning environment for training purposes and prior to practice;
- self-assessment tool to monitor best practice;
- as a reflexive tool within supervision where supervisor and supervisee can work through different aspects of therapy and how and what interventions have been applied in particular situations throughout the duration of therapy.

The aims for the future are to undertake further reliability and validity testing of the scale's existing items and factors. Second, having refined the scale, it is hoped the scale's utility could be proposed as a qualitatively meaningful clinical tool that could be used as evidence on practice. In the meantime, if trainee therapists and those qualified consider most (if not all) of the TA factors enveloped in the new TA scale within their everyday practice, the scale can be used as a means of guidance on good practice. Each may rest easy knowing that their work is ethical, informed, highly qualitative, and

reflects the collective opinions of many colleagues through many clinical experiences that are representative of a positive TA.

4.6 Strengths of the Study

The research involved different participants at different levels in their experiential practice, from different therapeutic orientations across the UK. Recruitment procedures allowed for voluntary participation with clear ethical guidelines on participants' rights prior to them giving written consent to participate. Debriefing opportunities were also offered to participants showing respect for their individual contributions and an understanding by the researcher on how their involvement in the research process was being protected. The research design also took account of the busyness of therapists in minimising the time needed within the respective data collection periods. The study was qualitative and quantitative, which added rigour to the topic under investigation. The data collection period (three phases) offered the reader clear steps on how each step was approached and demonstrated protocols on how the research was conducted by way of reflection on the many ethical considerations on the TA, acknowledged through the researcher's personal and professional reflexivity on methodological factors.

A rationale on each of the chosen methods for data collection, and how data was analysed, also supported the design. Views were provided subjectively on the lived experiences of participants, yet simultaneously, opinions were professional in attitude which together helped increase the understanding of how the TA is developed and maintained, moreover, the components that support measurement as viewed by different types of therapists. This led to a qualitative TA measurement tool being developed, and one that was significantly statistical, as shown in the EFA analyses to assist therapists in training, practice and clinical supervision over the course of their therapeutic work. A qualitative TA measurement tool developed in this study supports the principles and values of Counselling Psychology in maintaining reflective practice throughout the process of therapy.

The research design gave participants opportunities to reflect on their own practice, while at the same time make sound contributions to the topic of inquiry so that they

could consider their experiences for the future in protecting clients. This showed participants their experiences were valued and listened to. Honesty and integrity reflected in the data throughout the research process on the part of participants and the researcher.

The discussion section involved an integrative therapeutic standpoint (reflective of counselling psychology fundamental principles) and this also helped raise the reader's awareness to different ways therapists think and behave within their chosen orientation, and simultaneously reduce bias. On these counts, it is hoped the reader will be able to immerse themselves into the intricacies of the therapist's world, and left them with an appreciation of the many ethics involved as a true testament in protecting and empowering clients.

The study was timely in that it could help raise further awareness to the responsibilities therapists now hold in therapy and the issues on accountability that they need to consider in practice in producing evidence.

The factor structure (overall) reflected one that innately described Bordin's (1979) model, but this study developed on Bordin's model by emphasising a task-related TA (relationship building and managing the process) over the relational bond. These findings led to identifying more precisely the types of factors and tasks involved that are important for therapists to act upon at different stages of the therapeutic process and their responsibilities within this process. This factor structure therefore did not address just the 'what' in therapy, but the 'how and why' relevant to obtaining evidence. For example, this type of qualitative TA measure could help with the structure of practice where each component (item on the new TA measure) will have implications at all points of the therapeutic process as defined by many different therapists to enhance reflexivity. This means this type of TA measure that is qualitative in nature, could also help benchmark standards in practice acknowledged at explicit and implicit levels. Second, this type of qualitative measure could help overcome some of the complexities considered in quantitative measurement. Hence endorsing the TA as the best predictor of outcome (as it currently stands), as early on as possible within the therapeutic

process, will surely increase the necessary skills base, allowing for greater protection of clients.

4.7 Limitations of the Study

The limitations of this research in the first instance was that it was a relatively small sample and few male therapists participated, which could have affected the dynamics of what male therapists consider supportive to the TA because they might have different views to females. For example, there were no male participants in the focus group, and very few took part in the online survey. However, a more even gender sample of panel judges was inspiring. A relatively small sample in the quantitative analysis also means that while those who participated considered the TA measurement scale items as potentially heightening awareness in training, practice and supervision, this may not be the case for all therapists in the population based on how they practice, their beliefs on what develops and maintains the TA, or how it should be measured. Indeed some therapists may even question the TA's validity and applicability because the TA and therapeutic relationship are terms frequently used interchangeably.

The rationale given for a focus group discussion was provided in the methodology section. However, it is acknowledged that some methodological factors might have affected results, such as the use of the two measures introduced, despite the clear advantages provided in section 2.3.3 where measures are based on the collaboration between client and therapist. Second, the researcher did not want to be presumptuous by thinking that participants were knowledgeable about the TA and how it is currently measured despite providing an introduction to the TA before data was collected in all three phases. That said, there is certainly an appreciation that despite the benefits of the two measures, they might also have created limitations. As a case in point, the items within either or both TA measures could have influenced thinking on what is involved in the TA and TA measurement, whereas without the measures, there might have been more spontaneity that could have proved more qualitative to the underlying components of the TA, and, which could have subsequently unfolded in the dialogue more naturally, generating alternative items for the new TA measure to those identified in this study.

The study focused on TA statements most favourable to developing and maintaining the TA but it should also be noted that there is strength in recognising negative connotations that if handled well, can lead to a stronger TA. Both aspects are important in the learning process. Further, if no measures were involved in the focus group interview, or alternative ones provided (despite much overlap in TA measures), this could have also resulted differently. Thus conclusions drawn from the transcript of the focus group discussion on the TA and items identified in the construction of the new measure and how it might be measured in the future should be considered at the individual's discretion.

The study points out several advantages and disadvantages of a focus group discussion and these and other areas within the research design are expanded upon in the following section 'methodology reflexivity'. Also noteworthy, is that having the researcher as 'moderator/facilitator' within the same room as participants could have been intimidating in how participants responded with their views of the TA, despite the fact that participants (therapists) would be experienced in expressing their views on practice with honesty and integrity.

Another limitation that could have affected the results was that the researcher was the only person involved in the analyses. As documented in the methodology section, qualitative analyses can be subjective by their very nature. Although clearly defined steps were shown on performing the analyses at each phase of the research, other analysts or more than one analyst might have produced different findings.

Only eleven participants (panel judges) were available in phase two of the data collection despite much effort to obtain a larger sample. However, eleven is the acceptable minimum in this model, and this small number still allowed for a pure median value in the semi-interquartile-range analysis.

In this study, panel-judge participants were also therapists, so in phase two and phase three, therapists were measuring the views of other therapists although in each phase, the design included different participants. On further consideration of the research design, it is acknowledged by the researcher that some might justifiably consider why

clients could not have rated responses to TA statements as an alternative option, thus providing a different outcome. However, in the Thurstone model, according to Oppenheim (1992), this model required judges to be of a similar standing to those who would use the TA measure. Apparently, Thurstone previously experimented the procedure with students, and the outcome suggested a deeper degree of knowledge was needed on the theoretical and conceptual components underpinning the TA for an independent analysis. Clients might therefore need explicit training on the TA beforehand, to enable them to participate in an informed way, in a client-focused TA measurement design.

Finally, the use of EFA is a common quantitative process in TA measurement scale development in quantifying data and outcome. Although the data analyses procedures in this study has shown clear step-by-step approaches on how the data was statistically performed, and reasons clearly stated for the use of particular procedures, factor analysis theorists frequently remind us in the literature that the complexities involved in statistical analyses including human error can both affect results. At the end, in exploratory factor analysis, subjective interpretation is involved in naming the latent factors. In human research, subjective accounts can naturally affect results. Therefore it is acknowledged that other researchers replicating this design might have concluded the results as having different factor labels for different reasons.

4.8 Suggestions for Future Research

In this study, it was decided to research therapists only. Reasons for this design have been provided at several stages of the study including therapists' views on the TA are less documented, the proposal that therapists views seem to differ from clients, and yet, their role is of importance in therapy with increasing demands on their responsibilities. Thus therapists are involved in initiating, developing and maintaining the TA and guiding the therapeutic process. Taking into account that therapists are nowadays more accountable for their actions and thus responsible for managing the process of therapy, it would be fair to expect in the context of the therapeutic process that clients who are distressed should feel safe in the knowledge that what therapists offer them in therapy has been tried and tested from many angles (clients, therapists, observers and a

combination of all), so that they can rely on therapists' skills, professionalism and empathy in a 'nurturant' way to gaining autonomy in the process of their own well-being. Thus therapists need to help clients overcome their difficulties as the more vulnerable member of the therapeutic dyad. This means more rather than less focus should be invested in therapist research. Attention in this direction, on how therapists introspect and protect clients will not only continue to reflect the ethos on ethical counselling psychology principles and values, but in the busyness of day-to-day practice, and can so easily be overlooked when meeting targets and other professional responsibilities, etc. To this end, ongoing self-awareness will undoubtedly help build therapists' confidence in not only what they practise, but precisely how, in the name of evidence.

More male therapist research on the TA is also needed. Males, for many reasons, may view the TA differently to females, and it is important their voice is heard more in TA literature. A study that involves male and female focus groups could be a development of this study.

Focus groups without measures or using other TA measures could also provide more TA evidence for future comparative studies. Larger samples are needed to test the current new TA measurement scale factor findings, as this could also add rigour to the development of the new TA measure and improve the generalisability.

Finally, a study that investigates both therapists' and clients' views as a development of this study on their respective current beliefs regarding the TA factors identified, could also be conducive to therapists' awareness and ethical practice as continued professional development. Involving a much larger sample of both types of participants for robustness compared to the number of therapists available in the current study, would indeed help therapists appreciate the consequences of their own beliefs and actions and how these impact on clients at a vulnerable time in their lives.

Finally, the recruitment of larger numbers of therapists and clients being available at a mutually given time needs careful consideration, not only to concord with future research design in terms of the size of such studies, but deliberation should also take

place on the duration of studies which needs to account for 1) availability in both samples, 2) cultural changes across time, and, 3) current policies that govern how therapeutic services are commissioned with affirmation on what quality therapeutic practice is, and by which means it is tested.

4.9 Methodology Reflexivity

In this study, the researcher decided to provide a broad representation of how therapists view the TA through a mixed methodology design of qualitative and quantitative approaches. A pluralistic perspective was adopted, which frees the practitioner (therapist/researcher) to explore "a dialogue of offerings with their clients, going beyond purist approaches whilst harnessing these ideas within a clear structure of goals tasks and methods" (Lennie, 2011, p. 78).

Prior to the research, friends were invited to relay their views on the use of TA measurement scales to get a feel for how the scales might be perceived by potential clients and therapists, albeit hypothetically. This helped position the researcher from the standpoint of both client and therapist when considering the literature as well as the data and results of the research. As West (2013) reports, "it is usually not helpful to rush the final design of a research project including the choice of an appropriate methodology" (p.71). With this in mind, many decisions were thrown in and out of consideration, before the final choices were set, and before knowing what decisions would ultimately mean to the discipline of counselling psychology (and all this entails) in protecting vulnerable users of our services. In principle, clients needed to remain central to the research process, yet thoughts were also in the best interests of therapists in their support of clients, including the researcher's, moreover, trainees who are our future in psychological practice.

The design involved subjective/professional judgements, obtained through the contributions of different participants at different points of data collection. This meant the need to manage each of these processes appropriately on any given method of data collection and analysis, in order to prevent bias in the research investigation. The BPS (2009) and BPS (2007) were key guidelines in supporting these claims.

The focus group participants' contributions were unstructured, and this meant participants could freely express their views and at the same time relate to other views that could generate new ideas. Robson (2011) reports on several advantages and disadvantages of focus groups, and the former was addressed in the Discussion section: Chapter 4. Some disadvantages of focus groups discussed by Robson (2011) included, confidentiality, power struggles, being aware of the less articulate, lack of anonymity amongst participants and the level of experience of some participants over others. Each of the above issues was managed in a way that was ethically bound.

Written information on anonymity, confidentiality, and sources of help following the research, was issued in research packs prior to participation, to help minimise any potential harm **(**see appendices).

Throughout the research process, there was a need to be mindful from the outset that participants in the focus group and those who were panel judges (while not being totally anonymous among themselves) could have presented vulnerabilities. To ensure all remained protected, there was reinforcement on confidentiality matters at data collection points as a reminder that participants had agreed to abide by confidentiality written into their consent form and data collection instruction sheets. In addition, prior to the focus group audiotaping, participants were reminded of confidentiality, which also included protection of services and the public to guard against identifying information. Participants in the focus group were also informed that each participant be given a fair and just opportunity to express their views in the allocated time for data collection.

The researcher's position was explained as one of moderator/facilitator. This meant following initial guidance and instructions and opportunities for questions; the researcher was not involved in the discussion. As this phase of the research was unstructured, it allowed participants the freedom to speak freely, and rather than in a semi-structured interview situation where they would be questioned by the researcher. This part of the process was explicitly subjective in nature, yet it was clear from the transcript that participants were drawing on their professional and theoretical beliefs. This added quality to the data.

It was also important to the researcher to be mindful that focus group participants were not only positioned in an unstructured group but that they were also unfamiliar with one another. This called for awareness on the possible effects upon participants when needing to be honest regarding how they practice. To help reduce the possibility of potential harm throughout the data collection process, and afterwards, possible vulnerabilities were not overlooked, for example, whether a participant felt they had said the right thing and appeared to regret it etc. That said, when considering the ethical risks of harm to participant in the design of the research, the probability of harm was considered minimal. As a case in point, reflecting on one's own practice is a regular task for therapists as part of their professional development, albeit not necessarily aloud in a focus group. Nonetheless, the researchers was alert to the fact that it was this phase of the research which created the most exposure for participants as they openly shared their views and self-explored personal and professional approaches to practice.

Participants who acted as panel judges were a different sample than those in the focus group. Although panel judge participants were required to score statements generated from the focus group transcript 'objectively', as described by Oppenheim (1992), realistically, views were based on their professional judgements (explained earlier in section 2.3.9). Participants' views were expressed independently and confidentially to ensure the ethical standpoint in protecting these participants regarding pre and post data collection was observed. Any questions that were asked during pre-data collection periods were dealt with respectfully, ensuring that explanations were given that did not affect the participants' understanding of what was required.

The online data collection was open to qualified therapists and trainee therapists. This phase of the research required a wider sample, representative of therapists practising today in the UK. All participants in the three phases of the research were given opportunities to discuss their research contributions post data collection. They were able to contact the researcher directly and confidentially via email, for any comments or confidential feedback regarding their participation. Participants were also invited to contact the researcher on the results of the research study.

Prior to data analysis, transcripts were rechecked to ensure nothing detrimental was stated by any of the participants that they might later consider to be harmful to

themselves or other participants, or that might lead to a misconstrued meaning by the reader. To prevent harm to any participant in the three phases of data collection (although data were analysed as to maintain complete anonymity for all), written and verbal explanation was given on how the data would be used in the study. Focus group participants were also offered the choice of having a copy of the audiotape, should they wish to query any of their data prior to analysis.

Further, participants in the focus group were informed that, where necessary, a word for word procedure would be used from transcripts without manipulation from the researcher. Procedures on withdrawal of data are stated in the participant's information form and consent form.

The new TA measurement scale items were generated through a transparent analysis process within the researcher's chosen methodology and detailed in the Data Analysis section. Reference to rationales for each phase of the data collection and analysis of results are also clearly presented.

Welsh (2002) highlights that in the interpretive stage of analysis with computer programs like NVivo, researchers may find differences in coding categories or themes in computer analysis than those undertaken manually. Although computer use on qualitative data analysis is increasing in popularity (Welsh 2002), as explained in this study, both methods of analysis have pros and cons. The important message relayed to the researcher when choosing these approaches was that both manual and computer methods of analysis have limitations. Yet both are needed to achieve credibility in the research study.

The statements (once generated) were judged by different participants to provide objective rather than subjective viewpoints on the TA concept. These participants were informed that any additional comments they wanted to make would be noted so that responses would not be skewed in any way. Explanation was given prior to data collection that the TA measure would be refined accordingly. Initial statement scores are shown in the appendices.

The exploratory factor analysis seemed an appropriate method to help uncover the underlying processes of the TA. The factor analysis procedures were followed to check

the factorability of the data. These steps are clearly detailed in the data analysis and results sections. There are many arguments in the literature on which factor analysis procedures may be best suited to the research topic. The decision on this was guided by reputable authors in the field of factor analysis such as Tabachnick and Fidell (2001; 2007), Field (2013), and Fabrigar and Wegener (2012) to name but a few. For example, the research was not developed on a pure empiricist standpoint. This allowed for an eye that reviewed the data empirically yet theoretically, with the aim to unravel some of the mysteries of the TA concept and to broaden understanding.

In the naming of the underlying TA factors, there was enthusiasm to be able to present newly named factors that were representative of the dynamics that are applied to therapeutic skills in developing and maintaining the TA. These are: relationship-building, managing the process, and relational bond. These descriptions truly fit a therapist's role in practice for future direction.

Finally, as the researcher, the experience of undertaking this study allowed for a position that became an enriched reflexive learning experience, not only through learning about the views and experiences of other participant therapists and trainees, but through the continued monitoring and recording of personal thoughts and feelings from the beginning and throughout the processes involved in ethical research and practice.

References

Ackerman, S., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*(2), 171-185.

Ackerman, S., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*(1), 1-33.

Anderson, L. W. (1981). *Assessing affective characteristics in the schools*. Boston: Allyn and Bacon, Inc.

Andrews, B. (2007). Doing what counts: *Human Givens, 14*(1), 32-37.

Andrusyna, T.P., Tang, T.Z., DeRubeis, R. J., & Luborsky, L. (2001). The factor structure of the Working Alliance Inventory in cognitive behavioral therapy. *Journal of Psychotherapy Practice and Research, 10*(3), 173-178.

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcomes in psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in Psychology, 2*(1), 270.

Arons, A. M. M., Krabbe, P. F. M., Schölzel-Dorenbos, C. J. M., Van Der Wilt, G. J., & Olde Rikkert, M. G. M. (2012). Thurstone scaling revealed systematic health-state valuation differences between patients with dementia and proxies. *Journal of Clinical Epidemiology*, *65*(8), 897–905.

Bachelor, A. (1995). Client's perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology, 42,* 323–337.

Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences and relationship to therapy outcome. *Clinical Psychology & Psychotherapy, 20*(2), 118–135.

Bachelor, A., & Horvath A. (1999). The therapeutic relationship. In Hubble, M.A., Duncan B.L., Miller, S.D., (Eds.), *The heart and soul of change: what works in therapy*. (pp. 133–78).Washington DC: American Psychological Association.

Bachelor, A., & Salamé, R. (2000). Participants perceptions of dimensions of the therapeutic alliance over the course of therapy. *The Journal of Psychotherapy Practice and Research, 9*(1), 39-53.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance–outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842–852.

Baillargeon, P., Coté, R., & Douville, L. (2012). Resolution process of therapeutic alliance ruptures: A review of the literature. *Psychology, 3(12),* 1049-1058.

Barker, C., Pistrang, N., & Elliott, R. (1994). Wiley Series in Clinical Psychology: Research Methods in Clinical and Counselling Psychology. Chichester, England: John Wiley & Sons.

Bazeley, P., & Jackson, K. (2013). *Qualitative Data Analysis with NVivo*. (2nd ed.). London: Sage Publications, Ltd.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beck, A. T. (1993). Cognitive therapy: Past, present, and future. *Journal of Consulting and Clinical Psychology, 61*(2), 194-198.

Beck, A.T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Bedi, R.P., & Duff, C.T. (2009). Prevalence of counselling alliance type preferences across two samples. *Canadian Journal of Counselling. 43*(3), 151-164.

Berg, B. L. (2001). *Qualitative research methods for the social sciences* (4th ed.). Boston: Allyn and Bacon.

Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology**.** *Counselling Psychology Review*. 25(4), 19-30.

Blow, A. J., & Distelberg, B. (2006). *Common factors in four evidence-based family therapy approaches.* Paper presented at the National Council on Family Relations Annual Conference, Minneapolis, MN.

Bond, T. (2004). *Ethical guidelines for researching counselling and psychotherapy*. Rugby: British Association for Counselling and Psychotherapy (BACP).

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*(3), 252-260.

Bordin, E. S. (1994). Theory and research on the therapeutic alliance: New directions. In A. O., Horvath, & L. S., Greenberg (Eds.). *The working alliance: Theory, research, and practice.* (pp. 13-37). New York: Wiley.

Brace, N., Kemp, R., & Snelgar, R. (2006). *SPSS for psychologists*. (3rd ed.). Basingstoke: Palgrave Macmillan.

British Association for Counselling and Psychotherapy (BACP). Retrieved April 3, 2013, from http://www.bacp.co.uk/

British Psychological Society (2007). *Guidelines for ethical practice in psychological research online, Report of the Working Party on Conducting Research on the Internet*. Retrieved October 23, 2012, from http://www.bps.org.uk/sites/default/files/documents/conducting_research_on_the_internet-guidelines_for_ethical_practice_in_psychological_research_online.pdf

British Psychological Society (2009). *Code of ethics and conduct: Guidance published by the Ethics Committee of the British Psychological Society*. Retrieved October 10, 2012, from http://www.bps.org.uk/system/files/documents/code_of_ethics_and_conduct.pdf

Burnard, P. (2002). *Learning human skills. An experiential and reflective guide for nurses and health care professionals*. (4th ed.). Oxford: Butterworth Heinemann.

Cahill, J., Barkham, M., Hardy, G. E., Gilbody, S., Richards, D., Bower, P., Audin, K., & Connell, J. (2008). A review and critical appraisal of measures of therapist-patient interactions in mental health settings. *Health Technology Assessment, 12*(24), iii-47.

Campbell, A., & Hemsley, S. (2009). Outcome Rating Scale and Session Rating Scale in psychological practice: Clinical utility of ultra-brief measures. *Clinical Psychologist, 13*(1), 1-9.
Castonguay, L., Constantino, M., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 271–279.

Castonguay, L.G., Constantino, M. J., McAleavey, A. A., & Goldfried, M. R. (2010). The Alliance in Cognitive-Behavioral Therapy. In J. C. Muran & J. P. Barber, (Eds.), The *Therapeutic Alliance: An Evidence-Based Approach to Practice and Training.* New York: Guilford Press.

Cecero, J., Fenton, L., Nich, C., Frankforter, T., & Carroll, K. (2001). Focus on therapeutic alliance: The psychometric properties of six measures across three treatments. *Psychotherapy: Theory, Research, Practice and Training, 38*(1), 1-11.

Cheung, G. W., & Renswold, R. B. (2000). Assessing extreme and acquiescence response sets in cross-cultural research using structural equations modelling. *Journal of Cross-Cultural Psychology, 31*(2), 187-212.

Child, D. (1990). *The essentials of factor analysis*. (2nd ed.). London: Cassel Educational Limited.

Clark-Carter, D. (2005). Harmonic Mean. *Encyclopaedia of statistics in behavioral science* Volume 2, John Wiley & Sons, Ltd, Chichester.

Constantino, M. J., Castonguay, L. G., & Schut, A. J. (2002). The working alliance: A flagship for the "scientist-practitioner" model in psychotherapy. In G. S. Tryon (Ed.), *Counseling based on process research: Applying what we know.* (pp. 81-131). Boston: Allyn and Bacon.

Constantino, M. J., Morrison, N. R., MacEwan, G., Boswell, J. F. (2013). Therapeutic alliance researchers' perspectives on alliance-centered training practices. *23*(3), 284-289.

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly.* London: Sage Publishing Ltd.

Cooper, M., & McLeod, J. (2011). *Pluralistic Counselling and Psychotherapy*. London: Sage

Corey, G. (2005). *Theory and practice of counseling and psychotherapy* (7th ed.). Belmont, CA: Brooks/Cole.

Corrie, S. (2010). What Is evidence? In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds), *Handbook Of Counselling Psychology* (pp. 44-61). London: Sage Publications.

Counselling Directory. Retrieved April 14, 2013, from http://www.counselling-directory.org.uk/

Crits-Christoph, P., Barber, J. P., Kurcias, J. S. (1993). The accuracy of therapists' interpretations and the development of the therapeutic alliance. *Psychotherapy Research, 3*(1), 25–35.

Crits-Christoph, P., Connolly Gibbons, M. B., Hamilton, J., Ring-Kurtz, S., Gallop, R. (2011). The dependability of alliance assessments: The alliance–outcome correlation is larger than you might think. *Journal of Consulting and Clinical Psychology: American Psychological Association*, *79*(3), 267–278.

Cushway, D. (2009). Reflective practice and humanistic psychology: The whole is more than the sum of the parts. In J., Stedmon, & R., Dallos (Eds.). *Reflective Practice in Psychotherapy and Counselling* (pp. 73-92). Maidenhead: Open University Press.

Dallos, R., & Stedmon, J. (2009). Flying over the swampy lowlands: Reflective and reflexive practice. In J., Stedmon, & R., Dallos (Eds.), *Reflective practice in psychotherapy and counselling* (pp. 1-22). Maidenhead: Open University Press.

Del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance–outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review*, *32*(7), 642–649.

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the non-specifics argument. *Clinical Psychology Science and Practice*, *12*(2), 174-183.

Dozier, M., & Tyrrell, C. (1998). The role of attachment in therapeutic relationships. In J. A., Simpson & W. S., Rholes (Eds.). *Attachment theory and close relationships.* (pp. 221-248). New York: Guilford Press.

Duncan, B. (2002). The Legacy of Saul Rosenweig: The profundity of the dodo bird. *Journal of Psychotherapy Integration*, *12*(1), 32-57.

Duncan, B., Miller, S., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. (2003). The Session Rating Scale: Preliminary Psychometric Properties of a "Working! Alliance Measure. *Journal of Brief Therapy, 3*(1), 3-12.

Duncan, B., Miller, S., & Sparks, J. (2004). *The heroic client: A revolutionary way to improve effectiveness through client directed, outcome informed therapy*. San Francisco: Jossey Bass.

Du Plock, S. (2010). Humanistic Approaches. In R., Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp.130-150). London: Sage Publications Ltd.

Elder, J. P., Wallace, C. J., Harris, F. C. (1980). Assessment of social skills using a Thurstone Equal-Appearing Interval scale. *Journal of behavioral assessment, 2*(3), 161-165.

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20*(2), 123-135.

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review, 28*(7), 1167-1187.

Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E. J. (1999). Evaluating the use of exploratory factor analysis in psychological research. *Psychological Methods, 4*(3), 272-299.

Fabrigar, L. R., & Wegener, D. T. (2012). *Exploratory factor analysis: Understanding statistics*. Oxford University Press.

Faw, L., Hogue, A., Johnson, S., Diamond, G. M., & Liddle, H. A. (2005). The Adolescent Therapeutic Alliance Scale: Development, initial psychometrics, and prediction of outcome in family-based substance abuse prevention counseling. *Psychotherapy Research, 15*, 141-154.

Field, A. (2013). *Discovering Statistics using SPSS for Windows*. (4th Ed.). London: Sage Publications Ltd.

Fife, S. T., Whiting, J. B., Bradford, K., & Davis, S. (2013). The therapeutic pyramid: A common factors synthesis of techniques, alliance, and way of being. *Journal of Marital and Family Therapy, 40*(1), 20–33.

Fishbein, M.A. (1967). Attitude and the prediction of behaviour. In M. Fishbein (Ed). *Readings in attitude theory and measurement.* (pp.477-492). New York: Wiley.

Foreman, S., & Marmar, R. (1985) Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry*, *142*(8), 922-926.

Frank, J. D. (1961). *Persuasion and healing*. Baltimore: Johns Hopkins Press.

Frank, J. D. (1973). Therapeutic components shared by all psychotherapies. In J. H., Harvey & M. M., Parks (Eds.). *The master lecture series. (Vol. 1). Psychotherapy research and behavior change* (pp. 77-122). Washington, DC: American Psychological Association.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Frederickson, J. (1999). *Psychodynamic Psychotherapy: Learning to listen from multiple perspectives*. Brunner/Mazel: London.

Freud, S. (1913). *On beginning the treatment: (Further recommendations on the technique of psychoanalysis*, *I*(12), 121-144.

Freyd, M. (1923). The graphic rating scale. *Journal of Educational Psychology, 14*(2), 83-102.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27*(2), 143–153.

Gelso, C. J., Kivlighan Jr., D. M., Busa-Knepp, J., Spiegel, E.B., Ain, S., Hummel, A. M., Ma, Y.E., Markin, R. D. (2012). The unfolding of the real relationship and the outcome of brief psychotherapy. *Journal of Counseling Psychology*, *59*(4), 495-506.

Gelso, C. J., & Samstag, L. W. (2008). A tripartite model of the therapeutic relationship. In S. D., Brown, & R. W., Lent (Eds.). *Handbook of counseling psychology*. (pp. 267–283). New York, NY: Wiley.

Gorsuch, R.L. (1983). *Factor Analysis*. Hillsdale, NJ: Erlbaum.

Green, S., Littell, J. H., Hamerstrom, K. T., & Tanner-Smith E. (2013). *The therapeutic alliance and psychotherapy outcomes for young adults aged 18 to 34: protocol for a systematic review*.

Graduate School of Social Work and Social Research Faculty Research and Scholarship Paper 61. Bryn Mawr. UK.

Greenberg, L. S., & Pinsof, W. M. (1986). *The psychotherapeutic process: A research handbook*. Guilford Press, New York.

Greenson, R. (1967). *The technique & practice of psychoanalysis.* New York: International Universities Press.

Hanson, W. E., Curry, K., T., & Bandalos, D. L. (2002). Reliability generalization of working alliance inventory scale scores. *Educational and Psychological Measurement, 62*(4), 659-673.

Hartley, J. (2013). Some thoughts on Likert-type scales. *International Journal of Clinical and Health Psychology, 13*, 83-86.

Hatcher, R. L. (1999). Therapist views of treatment alliance and collaboration in therapy. *Psychotherapy Research, 9,* 405–423.

Hatcher, R. L., & Barends A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology, 64*(6), 1326-1336.

Hatcher, R. L., & Barends A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Research, Practice, Training, 43*(3), 292-297.

Hatcher, R. L., Barends, A., Hansell, J., & Gutfreund, M. J. (1995). Patient's and therapist's shared and unique views of the therapeutic alliance: An investigation using confirmatory factor analysis in a nested design. *Psychoanalysis Quarterly, 63,* 636–643.

Haugh, S., & Paul, S. (2008). *The therapeutic relationship: perspectives and themes*. PCCS Books Limited: Gateshead, UK.

Hays, V.L. (1994). *The effects of the therapeutic alliance and social support on therapy outcome and mental health of women.* Unpublished doctoral dissertation, University of Wisconsin, Madison.

Heinonen, E., Lindfors, O., Härkänen, T., Virtala, E., Jääskeläinen, T., & Knekt, P. (2013). Therapists' Professional and Personal Characteristics as Predictors of Working Alliance in Short-Term and Long-Term Psychotherapies. [Electronic version] *Clinical Psychology Psychotherapy*, Jun 28. doi: 10.1002/cpp.1852. [Epub ahead of print]

Heinonen, E., Lindfors, O., Laaksonen, M. A., & Knekt, P. (2012). Therapists' professional and personal characteristics as predictors of outcome in short- and long-term psychotherapy. *Journal of Affective Disorders, 138*(3), 301-312.

Hogarty, K., Hines, C., Kromrey, J., Ferron, J., & Mumford, K.. (2005). The quality of factor solutions in exploratory factor analysis: The Influence of sample size, communality, and overdetermination. *Educational and Psychological Measurement, 65*(2), 202-26.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* (pp.37-69). New York, NY: Oxford University Press.

Horvath, A. O., Del Re, A., Fluckiger, C., & Symonds, D. B. (2011). Alliance in individual psychotherapy, *Psychotherapy*, *48*(1), 9-16.

Horvath, A. O., & Greenberg, L. (1986). The development of the Working Alliance Inventory: A research handbook. In L., Greenberg and W., Pinsoff (Eds.). *Psychotherapeutic processes: A research handbook*. New York: Guilford Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 64*, 223-233.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology*, *61*(4), 561-573.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology,* 38(2), 139-149.
Hougaard, E. (1994). The therapeutic alliance–A conceptual analysis. *Scandinavian Journal of Psychology*, *35*(1), 67-85.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis.

Qualitative Health Research, 15(9), 1277-1288.

IBM Corp. Released 2012. *IBM SPSS Statistics for windows*, Version 21.0. Armonk, NY: IBM Corp.

Imel, Z. E., Hubbard, R. A., Rutter, C. M., & Simon, G. (2013). Patient-rated alliance as a measure of therapist performance in two clinical settings. *Journal of Consulting and Clinical Psychology, 81*(1), 154-65.

Jacobs, M. (2004). *Psychodynamic Counselling In Action*, (3rd ed.). Counselling in action, Series Editor, Windy Dryden. London: Sage Publications Ltd.

Jordan, R. (2009). Adapt, Research and Survive! Taking counselling psychology into the next decade. *Counselling Psychology Review, 24*(1), 11-14.

Karlin, B. E., Trockel, M., Brown, G. K., Gordienko, M., Yesavage, J., & Taylor, C. B. (2013). Comparison of the effectiveness of cognitive behavioral therapy for depression among older versus younger veterans: Results of a national evaluation. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*. (Epub ahead of print).

Kasket, E. (2012). Dialogues and Debates: The Counselling Psychologist Researcher. *Counselling Psychology Review, 27*(2), 64-73.

Kitzinger, J. (1995). 'Introducing focus groups', *British Medical Journal*, 311(7000), 299-302.

Kline, P. (2000). A psychometrics primer. London: Free Association Books.

Krabbe, P.F.M. (2008). Thurstone scaling as a measurement method to quantify subjective health outcomes. *Med Care, 46*(4), 357-365.

Krause, M., Altimir, C., Horvath, A. (2011). Deconstructing the therapeutic alliance: reflections on the underlying dimensions of the concept. *Clínica y Salud, 22*(3), 267-283.

Krippendorff, K. (2004). Content Analysis: An introduction to its methodology (2nd ed.). Sage Publications Ltd.

Kroese, B. S., Dagnan, D. and Loumidis, K. (Eds.). (1997). *Cognitive-behaviour therapy for people with learning disabilities.* London: Routledge.

Kuusisto, K., Knuuttila, V., & Saarnio, P. (2011). Pre-treatment expectations in clients: impact on retention and effectiveness in outpatient substance abuse treatment. *Behavioural and Cognitive Psychotherapy, 39*(3), 257-271.

Laidlaw, K., Thompson, L. W., Dick-Siskin, L., & Gallagher-Thompson, D. (2003). *Cognitive Behavioural Therapy with Older People.* Chichester: Wiley.

Lambert, M. J. (2004). (Ed.). *Bergin & Garfield's handbook of psychotherapy & behaviour change.* (5th ed.). New York: Wiley.

Lambert, M. J. (2010). *Prevention of treatment failure. The use of measuring, monitoring and feedback in clinical practice*. Washington DC: American Psychological Association.

Lane, D. A., & Corrie, S. (2006). *The modern scientist-practitioner: A guide to practice in psychology.* London and New York: Routledge, Taylor & Francis Group

Lennie, C. (2011). Pluralistic counselling and psychotherapy: Mick Cooper and John McLeod. Sage Publications 2010, Reviewed by Clare Lennie, *Counselling Psychology Review, 26*(2), 78-79.

Levine, D. W., Kaplan, R. M., Kripke, D. F., Bowen, D. J., Naughton, M. J., & Shumaker, S. A. (2003). Factor Structure and Measurement Invariance of the Women's Health Initiative Insomnia Rating Scale. *Psychological Assessment, 15*(20), 123-136.

Likert, R. (1932). A technique for the measurement of attitudes. *Archives of Psychology, 140*, 5-55.

Lilienfeld, S. O., & Arkowitz, H. (2012). Are all psychotherapies created equal? Facts and fictions in mental health, *Scientific American Mind. 23*(4): Retrieved November 6, 2013, from http://www.scientificamerican.com/article/are-all-psychotherapies-created-equal/

Loewenthal, K. M. (2001). *An introduction to psychological tests and scales.* (2nd ed.). London: Psychology Press.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* New York: Basic Books.

Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: factors explaining the predictive success. In A. O. Horvath, & L. Greenberg, L. (Eds.). *The Working Alliance: Therapy, Research and Practice*. (pp.38-50). New York: Wiley.

Luborsky, L., Barber, J. P., Siqueland, L., & Johnson, S., Najavits, L. M., Frank, A., & Daley, D. (1996). The revised Helping Alliance questionnaire (HAQ-II): Psychometric properties. *Journal of Psychotherapy Practice & Research, 5*(30), 260-271.

Luborsky, L., Crits-Christoph, P., Alexander, L., Margolis, M., & Cohen, M. (1983). Two helping alliance methods for predicting outcomes of psychotherapy: A counting signs vs. a global rating method. *Journal of Nervous and Mental Disease, 171*(8), 480-491.

Luborsky, L., Crits-Christoph, P., Mintz, J., and Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting Therapeutic Outcomes*. Basic Books: New York.

Luborsky, l., Barber, J.P., Siqueland, L., Johnson, S., Majavits, L.M., Frank, Q., & Daley, D. (1996). The revised helping alliance questionnaire (HAQ-II). Psychometric Properties. *Journal of Psychotherapy Practice, 5*(3), 260–271.

Lutz, W., Leon, S. C., Martinovich, Z., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counseling Psychology, 54*, 32-39.

Marmar, C. R., & Gaston, L. (1988). *Manual for the California Psychotherapy Scales-CALPAS.* Unpublished manuscript, University of California, San Francisco, CA.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Counseling and Clinical Psychology, 68*(3), 438-450.

Matsunaga, M. (2010). How to Factor Analyze Your Data Right: Do's Don'ts and How-To's. *International Journal of Psychological Research, 3*(1), 97-110.

Mauthner, N. S., & Doucet, A. (2003). Reflexive Accounts and Accounts of Reflexivity in Qualitative Data Analysis. *Sociology, 37*(3), 413-431.

Mayring, P. (2000). *Qualitative content analysis.* Forum: Qualitative Social Research, 1(2). Retrieved May 3, 2012, from http://www.utsc.utoronto.ca/~kmacd/IDSC10/Readings/text%20analysis/CA.pdf

McEvoy, P. M., Burgess, M. M., & Nathan, P. (2014). The relationship between interpersonal problems, therapeutic alliance, and outcomes following group and individual cognitive behaviour therapy. *Journal of Affective Disorders, 157,* 25-32.

McLeod, J. (2003a). The Humanistic Paradigm. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.). *Handbook of Counselling Psychology* (pp.140-160). London: Sage Publications.

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review, 31*(4), 603-616.

Mearns, D. (2003). *Developing Person-Centred Counselling.* London: Sage Publications Ltd.

Mearns, D. & Cooper, M. (2009). *Working at relational depth in counselling and Psychotherapy*. London: Sage Publications Ltd.

Meier, P. S., Donmall, M.C., McElduff, P., Barrowclough, C., & Heller, R.F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug Alcohol Dependent, 83*(1), 57-64.

Miller, S. D., & Duncan, B. L. (2000). T*he outcome and session rating scales: Administration and scoring manuals.* Retrieved December 10, 2014, from http://www.talkingcure.com

Miller, S., Duncan, B., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of reliability, validity, and feasibility of a brief visual analogue measure. *Journal of Brief Therapy, 2*(2), 91-100.

Muran, J. C. (1993). The self in cognitive-behavioral research: An interpersonal perspective, *The Behavior Therapist, 16*, 69-73.

Muran, J., C., & Barber, J.P. (2010). *The therapeutic alliance: An evidence-based guide to practice*. New York: Guilford Press.

Niemeyer, K.M. (2004). An explanation of object relations and the early working alliance in a university clinic sample. *Dissertation Abstracts International, 65*(8-B), 4298.

Newbigging, K., & Heginbotham, C. (2010). *Commissioning mental well-being: A leadership brief for boards and senior managers: The role of wellbeing and mental health promotion in achieving whole system improvement*. Retrieved June 3 2012, from http://www.emcouncils.gov.uk/write/commissioning-for-wellbeing-and-population-mental-health.pdf

Norcross, J. C. (2002). (Ed.). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs*. New York: Oxford University Press.

NVivo. (2012). *Qualitative data analysis software:* QRS International Pty Ltd. Version 10

O'Brien, A.J. (2001). The Therapeutic relationship: historical development and contemporary significance. *Journal of Mental Health Nursing, 8*(2), 129-137.

O'Brien, M. (2010). Towards Integration: In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp. 173-192). London: Sage Publications, Ltd.

Okiishi, J. C., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003), Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy, 10*(6), 361-373.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*(9), 1157-1172.

Oppenheim, A.N. (1992). *Questionnaire design, interviewing and attitude measurement*. London.

Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of process-outcome research: Continuity and change. In M. J., Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.) (pp.307-390). New York: Wiley.

Pallant, J. (2005). *SPSS survival manual*. London: Open University Press.

Persons, J. B., Burns, D. D., & Perloff, J. M. (1988). Predictors in dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive Therapy and Research, 12*, 557-575.

Pett, M., Lackey, N., & Sullivan, J. (2003). *Making sense of factor analysis: the use of factor analysis for instrument development in health care research.* London: Sage Publications, Ltd.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research In Hayes, N. (ed) (1997). *Doing qualitative analysis in psychology* (pp.245-273). Hove, England: Psychology Press/Erlbaum: Taylor & Francis.

Prochaska, J. O., Norcross, J. C., & Diclemente, C. C. (2013). Applying the stages of Change. *Psychotherapy in Australia, 19*(2), 10-15.

Proctor, G. (2002). *The dynamics of power in counselling and psychotherapy: Ethics, politics and practice.* Ross-On-Wye: PCCS Books.

Reese, R. J., Norsworthy, L A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 418-431.

Rizq, R. (2013). The language of healthcare. *Therapy Today, 24*(2), 20-24.

Robertson, D. (2010). *The philosophy of cognitive behavioural therapy: Stoic philosophy as rational and cognitive psychotherapy*. Karmac: London.

Robson, C. (2011). Real World Research. (3rd ed.) Wiley Publications: Chichester.

Rogers, C. R. (1951). *Client-centered therapy*. Boston, MA: Houghton-Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality changes. *Journals of Consulting and Clinical Psychology, 21*(2), 95-103.

Rogers, C. R. (1963). The actualizing tendency in relation to "motive" and to consciousness. In M. Jones, (Ed.). *Nebraska symposium on motivation*. (pp.1-24). Lincoln: University of Nebraska Press.

Rohrmann, B. (2003). Verbal qualifiers for rating scales: Sociolinguistic considerations and psychometric data, Project Report at the University of Melbourne/Australia. Retrieved February 8, 2013, from http://www.rohrmannresearch.net/pdfs/rohrmann-vqs-report.pdf

Roos, J., & Werbart, A. (2013). Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review. *Psychotherapy Research, 23*(4), 394-418.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the Therapeutic Alliance.* New York: Guildford Press.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*, 412-415.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, 43*(3), 286-291.

Sajatovic, M., Ramirez L. (2003). *Rating scales in mental health*. (2nd ed.). Cleveland, OH: Lexi-Comp, Inc.

Saldaña, J. (2009). *The coding manual for qualitative researchers*. London: Sage Publications Ltd.

Salkovskis, P., Clark, D.M. (1998). *Frontiers of cognitive therapy: The state of the art and beyond*. New York, NY: Guilford Press.

Shillito-Clarke, C. (2003). Ethical Issues in Counselling Psychology. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.), *Handbook of Counselling Psychology* (pp.615-633). London: Sage Publications, Ltd.

Shillito-Clarke, C. (2010). Ethical issues in counselling psychology. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp. 507-528). London: Sage Publications, Ltd.

Sims, C. (2010). Counselling psychology in forensic settings. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of Counselling Psychology*. (pp. 454-465). London: Sage Publications, Ltd.

Spector, P. E. (1992). *Summated rating scale construction, an introduction*. London: Sage Publications, Ltd.

Spurling, L. (2004). An introduction to psychodynamic counselling: basic texts in counselling and psychotherapy. Series Editor: Stephen Frosh. Palgrave Macmillan: London.

Stallard, P. (2002). Think good-feel good: A cognitive behaviour therapy workbook for children and young people. Chichester: Wiley.

Sterba, R. (1934). The fate of the ego in analytic therapy. *International Journal of Psychoanalysis, 15,* 117-126.

Stevens, R. (2002). *Understanding the self. Social psychology*. London: Sage Publications, Ltd.

Strawbridge, S., & Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe, S. Strawbridge, & W. Dryden (Eds.). *Handbook of Counselling Psychology*. (2nd ed.). (pp.3-21). London: Sage Publications, Ltd.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp. 3-22). London: Sage Publications, Ltd.

Streatfield, N. (2012). Measuring outcomes. *Therapy Today, 23*(1), 28-31.

Strupp, H. H., & Hadley, S. W. (1979). Specific vs. nonspecific factors in psychotherapy: A controlled study of outcomes. *Archives of General Psychiatry, 36*(10), 1125-1136.

Suh, C. S., Strupp, H. H., O'Malley, S. S. (1986). The Vanderbilt process measures: the psychotherapy process scale (VPPS) and the negative indicators scale (VNIS). In L. S.

Greenberg, & W. Pinsof, (Eds.). *The Psychotherapeutic Process: A Research Handbook.* (pp. 285-323). New York: Guilford Press.

Summers, R. F., & Barber, J. P. (2003). Therapeutic alliance as a measurable psychotherapy skill. *Academic Psychiatry, 27*(3), 160-165.

SurveyMonkey.com. Retrieved July 22, 2013, from https://www.surveymonkey.com/?ut_source=header

Tabachnick, B. G., & Fidell, L. S. (2007). *Using Multivariate Statistics*. Boston: Pearson Education, Inc.

Tabachnick, B.G., & Fidell, L S. (2001). *Using Multivariate Statistics* (4th ed.). Boston: Allyn and Bacon.

Tavakol, M., & Dennick, R. (2001). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2*, 53-55.

Teyber, E., & Holmes McClure, F. (2011). *Interpersonal process in therapy: An Integrative Model* (6th ed.). USA: Cengage.

Thurstone, L. L., & Chave, E. J. (1928). Attitudes can be measured. *American Journal of Sociology, 33*, 529-554.

Thurstone, L. L., & Chave, E. J. (1929). *The measurement of attitude*. Chicago: The University of Chicago Press.

Timulak, L. (2011). *Developing your counselling & psychotherapy skills & practice*. London: Sage Publications Ltd.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1*, 207-210.

Trochim, W.M. (2006). The research methods knowledge base (2md ed.) Retrieved August 3, 2013, from http://www.socialresearchmethods.net/kb/citing.php.

Unsworth, G., Cowie, H., & Green, A. (2012). Therapists' and clients' perceptions of routine outcome measurement in the NHS: A qualitative study. *Counselling and Psychotherapy Research:* Linking research and practice, *12*(1), 71-78.

Waller, G., Evans, J., & Stringer, H. (2012). The therapeutic alliance in the early part of cognitive-behavioral therapy for the eating disorders. *International Journal of Eating Disorders, 45*(1), 63-69.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

Watkins, M. W. (2006). Determining parallel analysis criteria. *Journal of Modern Applied Statistical Methods, 5*(2), 344-346.

Welsh, E. (2002). *Dealing with Data: Using NVivo in the qualitative data analysis process* [12 paragraphs]. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 3(2), Art. 26. Retrieved August 4, 2013, from http://www.qualitative-research.net/index.php/fqs/article/view/865/1881.

West, W. (2013). Making methodological choice in counselling research. *Counselling Psychology Review, 28*(3), 66-72.

Willig, C. (2001). Introducing qualitative research in psychology: Adventures in theory and method. Berkshire: The Open University Press.

Willig, C. (2008). Discourse analysis. In J. A. Smith (Ed.). *Qualitative psychology: A practical guide to research methods.* (2nd ed.). (pp.160-185). London: Sage Publications, Ltd.

Wolfe, B. E., & Goldfried, M. R. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology, 56*(3), 448-451.

Zetzel, E. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37,* 369-375.

Appendices

Appendix I: Permission Request Form –Work-Base Provider /Manager

Principal Investigator: Dr Don Rawson, [redacted]
Researcher: Alison Walne, [redacted] City University, London, Schools of Arts & Social Sciences, City University, Northampton Square, London, EC1V 0HB. T: +44 (0)20 7040 4566

Title: Therapists Views on the Therapeutic Alliance and Factors Involved in Therapeutic Alliance Measurement

Dear Sir/Madam,

I would like your permission to approach therapists in your service to participate in my research. A permission reply slip is provided for your convenience and can be forwarded to the Researcher via the above e mail address. If you agree:

Your involvement:

- Please display a recruitment poster in the staff communal area
- Please distribute research information packs to prospective participants upon their request.

I am a HCPC Registered / BPS Chartered Counselling Psychologist on the Post-Chartered Doctorate in Psychology programme at City University, London. The programme involves conducting a research study investigating therapists' understanding of the therapeutic alliance (TA), and, through self-reflection on their therapeutic practice, what skills therapists feel are important to help develop and maintain a positive therapeutic alliance.

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London (project approval number: Reference: **'PSYETH 11/12 005'.**

The inclusion criteria: to participate in this study, participants are required to be:

- a qualified therapist who has completed a minimum 2 year therapeutic training programme, and be in current practice which requires therapeutic work on a one to one basis
- able to speak English,
- be willing to travel to a local venue to participate in either a focus group or contribute as a panel judge,
- willing for data collection to be audio-taped,
- able to access e mail for communication with the researcher (if needed).

This research study will comply with all mandatory requirements under the Data Protection Act 1998. The research packs will be sent to you approximately 2 weeks after permission is obtained. If you have any queries please contact me or my Research Supervisor, as stated above. The Participant's Information Form, providing details of the research study, will be issued to participants prior to voluntary participation, and is enclosed for your further reference. Participants will be asked to sign a consent form.

Yours sincerely,

Alison Walne, Researcher

Appendix 2: Permission Reply Slip

(Please return via e mail)

Title: Therapists Views on the Therapeutic Alliance and Factors Involved in Therapeutic Alliance Measurement

Principal Investigator: Dr Don Rawson, [redacted]
Researcher: Alison Walne, [redacted] City University, London, Schools of Arts & Social Sciences, City University, Northampton Square, London, EC1V 0HB. T: [redacted]

I give permission for therapists at this service to voluntarily participate in the research study described in Participant's Information Sheet. I understand the research will be undertaken by the Researcher, Alison Walne, City University, London, and that this project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London (project approval number: Reference: **'PSYETH 11/12 005'.**

Service Provider /Manger:

Name: ..... (Please print).....

Designated Title: .....Signed: .....

Date: .....

Thank you

Alison Walne

Researcher

Appendix 3: Permission Reply – Return 1

Alison Walne
Researcher

Appendix II

PERMISSION REQUEST FORM - REPLY SLIP (Please return via e mail)

Title: Therapeutic Alliance Measurement. What factors are involved?

Principal Investigator: Dr Don Rawson, [redacted]
Researcher: Alison Walne, [redacted] City University, London, Schools of Arts & Social Sciences, City University, Northampton Square, London, EC1V 0HB. T: +44 [redacted]

I give permission for therapists at this service to voluntarily participate in the research study described in Participant's Information Sheet. I understand the research will be undertaken by the Researcher, Alison Walne, City University, London, and that this project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London (project approval number: Reference: **'PSYETH 11/12 005'.**

Service Provider /Manger:

Name: .[redacted]..... (Please print)

Designated Title: ..[redacted] Signed: ..[redacted].....

Date: [redacted]

Thank you

Alison Walne
Researcher

Appendix 5: Recruitment Poster

Research Recruitment Poster

This organisation has kindly given permission for an independent research study to be conducted with service therapists or private practitioners currently in therapeutic practice.

The aim is to help psychology better-understand the specific factors involved in the Therapeutic Alliance and to create a new therapeutic alliance measure to help enhance awareness on alliance processes.

At a location convenient to you, the research will involve giving views on what you believe helps develop and maintain a positive therapeutic alliance by contributing in a focus group or as a judge on a panel. Demographic information will need to be completed as part of the research task. Focus group data will be audio-taped.

Either research task = maximum 60 minutes.

For your protection, your anonymity will be maintained by the researcher and respected by other participants. Your responses will be completely confidential. The research will be carried out at an agreed time with participants.

Even if you do decide to take part in the research, you are free to withdraw at any point.

If you decide to participate, your contributions to this study will be highly valuable in helping to support therapists and trainees in practice and supervision, and through the knowledge gained from this study, assist those who are at the forefront of providing therapeutic practice training.

Research packs can be obtained from your work-base provider, which provides full details of the study.

Participants will be entered into a **£50** draw prize, via their personal ID research number - confidential to the researcher.

Thank you!

Alison Walne

Researcher – e mail: [redacted]

Appendix 6: Participant's Information Form (Explanatory statement)

Dear Participant,

Principal Investigator: Dr Don Rawson, [redacted]
Researcher: Alison Walne, [redacted] City University, London, Schools of Arts & Social Sciences, City University, Northampton Square, London, EC1V 0HB. T: [redacted]

Title: Therapists Views on the Therapeutic Alliance and Factors Involved in Therapeutic Alliance Measurement

I am a Counselling Psychologist on the Post-Chartered Doctorate in Psychology, Research Degree Programme at City University, London. As part of my Doctorate, I am conducting a research study investigating therapists involved in therapeutic work, understanding of the therapeutic alliance (TA). Through self-reflection on their therapeutic practice, the study will explore what skills therapists feel are important to help develop and maintain a positive therapeutic alliance, while raising awareness on their own therapeutic performance. The TA according to Bordin's (1979) Working Alliance Theory, is described as a mutual construct between client and therapist, and conceptualised as shared goals, tasks and an attachment bond, and, "as the vehicle through which psychotherapies are effective" (Summers & Barber, 2003, p.160). Current literature suggests that widely-used TA measures tend to focus on the non-specific (general) factors of the TA and remains unclear about what precisely drives the process. This study will explore these elements to help develop our understanding on TA processes which can also support knowledge on practice while in training. **Study findings** can be obtained by contacting the researcher on the above contact details.

The inclusion criteria for the research:

- you are a qualified therapist over 18 years of age who has completed a minimum 2 year therapeutic training programme, and in current practice (local service or private practice) which offers therapeutic work on a one to one basis
- you are able to speak English,
- you agree to participate in one Focus Group or contribute as a Judge on a Panel, to assess data,
- you agree to complete a Demographic Information Form,
- you have access to e mail for correspondence from the researcher,
- be willing to attend a local venue to participate in the research.

Audio-tape: The Focus Group data collection will be audio-taped. Guidance on protecting your anonymity and that of other participants will be given verbally prior to your participation and collection of any data. Your data will be given a code and a number to protect your identity, and the researcher will comply with all mandatory requirements under the Data Protection Act 1998 and Research Integrity policies stated by City University, London. Any quotes or statements made during recording in the data analysis will be kept completely anonymous.
Voluntary participation: Your participation in this research is voluntary. You are free to withdraw at any time without giving a reason or, withdraw use of your data. If during the data collection process you do not want to answer a question, you have the right to do so. Prior to participating in the study, you will be given verbal information by the researcher, on debriefing procedures in respect of your participation in the research, and as outlined below.

Comments, concerns or observations procedure:

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London (project approval number: Reference: **'PSYETH 11/12 005'.**

If you have any comments, concerns or observations about the conduct of the study or your experiences as a participant, please contact the Secretary to the Committee XXXXX quoting the above project approval number:
Telephone: [redacted].
Email: xxxxx@city.ac.uk
Postal Address: XXXXX (Please continue overleaf).
Secretary to Psychology Department Research and Ethics Committee, School Office, Schools of Arts and Social Sciences, City University, Northampton Square, London. EC1V 0HB"

Complaints: To make a complaint about any part of the research study. Please contact *Anna Ramberg, Secretary to the Senate Ethics Committee* City University. Contact Tel. number [redacted]. Email: [redacted].

Data collection, Storage and Destruction: Data collected for this research will only be used for this study. Data will be held and stored securely by the researcher in a locked cabinet. Your signed consent form will be stored separately from your data throughout the research process to protect your anonymity. The destruction of data will take place after the completion of the study, and in line with City University's policies on data collection, storage and destruction. Enclosed is the following:

- **Participant's Information Form** on the research study - as above.
- **Consent Form** which requires your name, signature and date, to acknowledge your agreement to take part in the research. **A stamped address envelope** is enclosed for return.
- **Debriefing Information, Retrieval of Data, and How to Obtain Research Findings Form.**

Please retain the Participant's Information Form and Debriefing Information, Retrieval of Data, and How to Obtain Research Findings Form for your records.

Thank you

Alison Walne

Researcher

Appendix 7: Participant's Consent Form

Researcher: Alison Walne, [redacted]City University, London, Schools of Arts & Social Sciences, City University, Northampton Square, London, EC1V 0HB. T: [redacted]

My name is Alison Walne and I am currently undertaking the Post-Chartered Doctorate in Psychology programme, at City University, London. Please read all the information provided on this form, and then below, please print and sign your name, and date the form for return in the stamped address envelope provided.

I have been provided with a research information pack, and I meet the inclusion criteria as stated in the Participant's Information Form. I agree to take part in the above City University research study. I have had the study explained to me, and I have read the Participant's Information Sheet, which I will keep for my records. I understand by agreeing to take part in the research, this confirms that I meet all inclusion criteria as stated in the Participant's Information Form, and that I am willing to:

- be part of a focus group, or be a judge on a panel to assess data,
- allow the focus group data collection to be audio-taped (if applicable to me),
- complete a questionnaire for demographic information, and

This information will be held and processed for the following purpose(s): (to help develop knowledge on the therapeutic alliance and what skills this involves).

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand my data will be given a code and a number to protect my **anonymity** and the research will confer to all mandatory requirements under the **Data Protection Act 1998** and in line with the British Psychological Society, Code of Ethics and Conduct (2009). All data will be stored securely by the researcher, and at no point will unauthorised persons be privy to the data.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the study, and that I can **withdraw** my data at any stage without being penalised or disadvantaged in any way. I understand that my data will not be used in any future study. I also understand I will be given information prior to my participation, on debriefing procedures and support I could access, should I wish to do so following my participation in the research.

Comments, concerns or observations procedure:

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London (project approval number Reference: **'PSYETH 11/12 005'**
If you have any comments, concerns or observations about the conduct of the study or your experiences as a participant, please contact the Secretary to the Committee XXXXX quoting the above project approval number: **Telephone:** [redacted]. **Email:** XXXXX **Postal Address:**
Secretary to Psychology Department Research and Ethics Committee, School Office, Schools of Arts and Social Sciences, City University, Northampton Square, London. EC1V 0HB"

Name: .....(please print). Contact E mail:.....

Work-Base.....Contact Tel:.....

Signature:.....

Date:.....

Your signed consent form will be retained and stored separately from your data throughout the research process. I will contact you via e mail following receipt of your signed consent form to provide research and venue instructions. **Please return within 2 weeks** of receipt of this information.

Thank you for agreeing to participate in this research study. Alison Walne, Researcher

Appendix 8: Debriefing Information / Retrieval of Data / How to Obtain Research Findings

This information will also be given verbally to participants at the commencement of their participation in the research, and before audio-recording of data.

Debriefing Information

Researcher: Alison Walne

Contact Details: E mail: [redacted] City University, London.

Please note that when any person takes part in psychological research they may experience many emotions regarding the information they have offered. Having your thoughts and feelings audio-taped in the process of data collection, can sometimes leave a person feeling vulnerable and make them wonder if they have done the right thing.

If at any point during or after the research, you would like to discuss any such matters, please either contact the researcher, or speak to your clinical supervisor.

Retrieval of Data

Any participant wishing to retrieve their data from the research study may do so. However, please be aware that withdrawal of data may conflict with anonymity regarding cross-referencing your data numerical code with consent form. Confidentiality will be respected if needing to contact the researcher data.

How to Obtain Research Findings

Following the completion of this study estimated date (XXXXX) you may contact the researcher by e mail as stated above, to obtain the results of the study.

Thank you very much for your support with this research study.

Please retain this information for your reference.

Alison Walne

Researcher

Appendix 9: Return of Consent Form – E mail Reminder

Dear Work-Base Provider /Manager,

Thank you for giving permission to conduct a research study courtesy of your therapists. Thank you also for agreeing to display a Research Recruitment Poster requesting voluntary participants from your services for my research study.

The study has been approved by the Research and Ethics Committee of the Department of Psychology of City University London (project approval number: Reference: **'PSYETH 11/12 005'.**

As yet, I do not seem to have received many consent forms back. Please could I ask you to circulate this e mail to therapists in your service to help me acquire more participants?

Please note: Therapists are under no obligation to participate.

If I have not received any further consent forms in 2 weeks from today's date, I will assume that any other therapists from your service do not want to participate in the study.

I would like to take this opportunity to thank you for your assistance with the recruitment process.

Kind regards,

Alison Walne

Researcher

Appendix 10: Demographic Information Form

DEMOGRAPHIC INFORMATION FORM

Please tick your job title and boxes below. Any information you provide will be anonymous and treated as confidential.

Job Tile

Psychologist

Psychotherapist

Counsellor

Gender: M ☐ F ☐ Age.....

Current Qualification. e.g. PhD, DPsych, Degree, Diploma, etc.....

Number of years post-qualification:

.....

Main Therapeutic Orientation: i.e. CBT / Person-Centred / Humanistic / Psychodynamic / Other.....

Please state which applies best to your current practice on the Therapeutic Alliance (TA) and if any, state which TA measures you use, i.e. Client /Therapist or both?

I use TA measures in therapy sessions.

Yes ☐ No ☐

I use TA measures in every session of therapy. State which? Client / Therapist /Both

Yes ☐ No ☐

I use TA measures at the beginning and end of therapy. Client / Therapist /Both

Yes ☐ No ☐

I use TA measures randomly in sessions.

.....

This information is asked of all participants in the study - <u>adapted for online participants.</u>

Thank you

Alison Walne

Researcher

Appendix 11: The Helping Alliance Questionnaire HAQ-II (Duplicate)

THE HELPING ALLIANCE QUESTIONNAIRE Therapist Version
INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your patient, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

	Strongly disagree	Slightly disagree	disagree	Slightly agree	agree	Strongly agree
1. The patient feels he/she can depend upon me.	1	2	3	4	5	6
2. He/she feels I understand him/her.	1	2	3	4	5	6
3. The patient feels I want him/her to achieve the goals.	1	2	3	4	5	6
4. At times the patient distrusts my judgment.	1	2	3	4	5	6
5. The patient feels he/she is working together with me in a joint effort.	1	2	3	4	5	6
6. I believe we have similar ideas about the nature of his/her problems.	1	2	3	4	5	6
7. The patient generally respects my views about him/her.	1	2	3	4	5	6
8. The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	1	2	3	4	5	6
9. The patient likes me as a person.	1	2	3	4	5	6
10. In most sessions, we find a way to work on his/her problems together.	1	2	3	4	5	6
11. The patient believes I relate to him/her in ways that slow up the progress of the therapy.	1	2	3	4	5	6
12. The patient believes a good Relationship has formed between us.	1	2	3	4	5	6
13. The patient believes I am experienced in helping people.	1	2	3	4	5	6
14. I want very much for the patient to work out his/her problems.	1	2	3	4	5	6
15. The patient and I have meaningful exchanges.	1	2	3	4	5	6
16. The patient and I sometimes have unprofitable exchanges.	1	2	3	4	5	6
17. From time to time, we both talk about the same important events in his/her past.	1	2	3	4	5	6
18. The patient believes I like him/her as a person.	1	2	3	4	5	6
19. At times the patient sees me as distant.	1	2	3	4	5	6

Reference

Luborsky, L., Barber, J. P., Siqueland, L., & Johnson, S., Najavits, L. M., Frank, A., & Daley, D. (1996). The revised Helping Alliance questionnaire (HAQ-II): Psychometric properties. *Journal of Psychotherapy Practice & Research, 5*(30), 260-271.

Appendix 12: Working Alliance Inventory –Therapist Version (Duplicate)

Working Alliance Inventory-Therapist
Short Form (Therapist)

Counselor ID# _____ Client Case# _____ Date _____
Measurement Point (circle one): 1st Week 3rd Week
Instructions:
On the following page there are sentences that describe some of the different ways you might think or feel about your client.
As you read the sentences mentally insert the name of your client in place of _____in the text.
Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly, your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You

Alison Walne

Researcher

Please see overleaf: WAI –Therapist –Short Form (Therapist).

Reference

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1*, 207-210.

1. _____ and I agree about the steps to be taken to improve his situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. My client and I both feel confident about the usefulness of our current activity in counseling.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I have doubts about what we are trying to accomplish in counseling.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in my ability to help _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. We are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciate _____ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8 We agree on what is important for _____ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I have built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas on what his real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding between us of the kind of changes that would be good for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. _____ believes the way we are working with her problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Appendix 13: Focus Group Instructions

Prior to your participation in the focus group, I will explain my position as moderator/facilitator of the focus group. I will then provide you with a brief overview of the Therapeutic Alliance and explain the data collection procedure. The focus group interview will be audiotaped following instructions.

As the researcher (moderator/facilitator) I will observe the discussion and ensure such things as fairness is maintained to protect participants but I will not make contributions to the discussion and data collection.

Many researchers believe the Therapeutic Alliance to be the best predictor of therapeutic outcome regardless of the therapeutic approach. Although much has been written on the TA concept, today there is no clear definition. The TA forms part of the Therapeutic Relationship and said to be the driving force through the process of therapy (Summers & Barber, 2003). A well-documented and popular definition in the literature was developed by Bordin (1979). Bordin suggests the TA is formed through shared goals, tasks and an attachment bond between client and therapist. This research is intended to explore your views on the TA through experiences with your own clients – past and present.

Individual Participant

1. Please fill in the demographic form provided

2. Please read through the contents on the 2 therapeutic alliance (TA) measurement scales - Working Alliance Inventory –Therapist Short Form and Helping Alliance Questionnaire – Therapist Version.

You will be allowed 10 minutes and can make notes as you wish. At this point, please consider the scales without sharing information with other participants present.

These scales are introduced to familiarise yourself with the type of contents included in TA measurement.

Please note, they are for optional use and reference throughout the discussion.

Following scale reference, and preceding the auidotaping, the researcher will provide a fair overview of current TA literature and the findings to date, to encourage participant views and to generate any new TA items.

All Participants

You are now asked to offer and share your opinions on the TA with the rest of the group (including reference to either or both measurement scales if you wish).

You are encouraged to offer any additional themes (items) that you think may help develop and maintain a positive Therapeutic Alliance.

For the purpose of data collection, and audio-recording, if commenting on either of the TA measurement scales provided, please state which scale you are commenting on when sharing your views? For example, "I note on the Helping Alliance Questionnaire on Question 6 etc..."

Please note: to protect your anonymity, and that of other participants during the recording period, please reframe from using participant names or other identifying information. In addition, please do not mention the name of your work-base or service, or supervisor's name etc. This helps protect all.

Thank you.

Alison Walne, Researcher

Appendix 14: Focus Group Interview Transcript and Manual Analysis

Focus Group Transcript	'In vivo' Manual Coding
1. P.1 Well, I found it really interesting to actually see this literature on the working alliance inventory 'cause it's something that I hadn't considered much before and certainly something that I don't use in my practice. Although some of these statements that are listed on here um I can sort of relate to. Um there's one on respecting views, which I think is probably quite important, which I use quite a bit. Respecting views of the client is quite important in what I do. Um and also funnily enough that the patient likes me [laughs] so I think that probably does make a difference to how my outcomes are or how I work with somebody. ___ getting that feeling that you actually get on with somebody and then, you know, there's that sort of relationship there.	Unfamiliarity Respect Support process Being liked
2. P.2 It's interesting 'cause I don't mind if a client doesn't like me as long as they respect what we're trying to do.	Respect for the work rather than the therapist
3. Mmhmm.	
4. And we can work together.	Collaboration -United
5. Yeah.	
6. P.2 So for me, it's not about being liked.	
7. Mmm.	
8. P.3 How can you be actually sure that somebody likes you or not? I'm curious. I -- I don't know. It's just --	Perception - Bond
9. P.1 I suppose that it's not so much likes me. It's more likes what we're doing together. Likes what's happening in -- in the -- in the room and the sort of work we're doing. I suppose you get the feedback from them about whether it's making a difference and by checking out with them that that's working for them. I suppose that's more -- rather than liking me personally. It's more to do with liking what I'm doing in the room and the process I suppose.	Mutual agreement on the work Reflection
10. P.7 I think I find that really important. What I've been looking at the working alliance inventory especially is that I feel without the client's perception, I question how valid it is. So it's obviously -- especially if I'm answering these questions as a therapist, I'm very conscious that's only one part of a bigger puzzle. And then therefore to see how valid they are would need the other side of that --	Bigger picture – needs to be holistic to have meaning Question on efficacy
11. Hmm.	
12. Mmm.	

13. P.5 -- that -- from which I actually is -- I don't use this one in practice either. Um but I would potentially look at exploring themes that might be on some of the questions within my sessions of helpfulness --	Helpfulness an Aide
14. Yeah.	
15. P.5 -- and that kind of scope. But I think for me as well -- and it's -- it may sound a little bit odd. It -- it's very much about chemistry. Therapies ___ alliance for me is very much about the chemistry within the room.	Chemistry –Bond Dynamic Atmosphere, something invisible or untouchable
16. Mmhmm.	
17. P.5 Chemistry. The atmosphere, the -- the dynamics between us. And I think I'm very conscious in the way that I work of the kind of very much the core conditions, but with honesty and acceptance and that kind of __ foundation of any alliance with a client I might work with.	Integrity structure to practice
18. P.7 How quickly would you see the therapeutic alliance beginning?	Timing
19. P.6 From the very first phone call or contact you have.	Instant
20. Mmhmm.	
21. P.3 I think it's really important.	
22. P.2 Cause that's very much dependent on voice, isn't it?	Client's pre-expectations
23. Mmhmm.	
24. P.2 If it's a telephone call --	
25. Mmm.	
26. P.2 -- rather than actual --	
27. P.2 Sort of friendliness, clarity?	Client pre-expectations
28. Yeah.	
29. P.2 It might even go back before that because if you like advertise on the internet or something like that --	Client –pre-expectations
30. Yeah.	
31. P.6 -- um it might go on how you look. I can remember having a client who had looked at me, at a couple of other therapists. And he decided that one was too young and he wasn't gonna be tellin' all his problems to some young girl. [laughs]	Client expectations
32. Mmhmm.	

33. P.6 One, he decided looked too snooty and stuck-up --	Pre-or misconceptions
34. [laughter]	
35. P.6 -- so there were his perceptions --	
36. P.6 Right.	
37. P.6 --of how he felt.	
38. Mmm.	
39. P.6 You know, he didn't actually say [laughs] what his perception was of me, but somehow -- somehow, you know, I was --	Intuition
40. Yeah.	
41. P.6 F: -- in the middle of these other ones. And -- and I might be okay. So yeah. So you haven't actually done anything.	Middle ground safety in the middle
42. No.	
43. No.	
44. P.6 You haven't done anything and it's already -- it's already started. I think I could work with that person.	Acceptance
45. Right.	
46. P.6 And that's just on a look ___ you know.	
47. P.6 So there's -- there's something intuitive that he knew --	Clarification
48. Yes.	
49. P.6 - about you --	
50. Or --	
51. P.6-- for his short imp—appearance.	
52. P.6 -- or -- or what he perceives how I look or --	Perception
53. Yes.	
54. P.7-- how somebody looks.	
55. Yeah.	
56. Yeah.	
57. P.4. I think it's very helpful now that there is the internet and people can do this trawling through and see people's photos --	Safety Barriers
58. Mmhmm.	
59. P.3 -- and a little description of them. Get a sort of sense of them because --	Insight

60. Mmhmm.	
61. P.6-- before that, it must have been very difficult to decide who to go to and ha-- have that sort of intuitive sense of who's going to fit.	Lack of choice
62. Yeah.	
63. P.2 You're going to feel comfortable --	Experiential
64. P.6 And then it might also go with what you've written 'cause obviously on -- on --	
65. Mmm.	
66. P.6 -- all these sites, you write your own things. You may have just written something that resonates --	Resonates with self
67. Mmm.	
68. Mmm.	
69. P.6 -- I've had a few people say that -- oh, what you wrote. That -- that -- that feels like me. You know, so they --	Resonates with self
70. Mmm.	
71. Mmhmm.	
72. P.6 -- it -- so there's -- you haven't even seen them face-to-face.	Intuition
73. [laughs]	
74. P.6 You haven't even had a conversation with them and it's already --	Intuition
75. P.7 So the relationship is starting before --	
76. P.7 It's already started.	
77. P.7 --they ever actually get into therapy.	Pre-therapy communication
78. P.4 So it'd be interesting to think that if that didn't happen -- if they didn't see you first and they were then sent to counseling without seeing the counsellor, it'd be interesting to see how that relationship develops because it wasn't their choice I suppose. They --	Spontaneity
79. Yeah.	
80. P.4 -- think didn't have a choice.	
81. P.4 I often find that because I'm -- the first time I will see some of my clients is when I walk in the waiting room to bring them in.	Spontaneity
82. Mmm. Mmhmm.	
83. P.4 And that's the first time.	

84. Mmm.	
85. P.4 They've not seen me on the internet.	Rawness
86. P.5 Well, that's, you know -- yeah. That's the difference between --	
87. Yeah.	
88. P.5-- private practice and when you're seeing someone --	Levels of service
89. P.3 Absolutely.	
90. P.5 -- in a -- in a different setting.	
91. P.1 So do you feel you have to work harder in that initial se-- that initial sess- session to build up that contact and bond compared to if that had already started to be built up through --	Greater effort
92. P.6 I personally --	
93. P.1-- picture and phones --	
94. P.1 ___ to think about.	
95. [laughs]	
96. P.2 I certainly noticed a difference when the internet started and we were able to do this. That I suddenly sort of found that I was getting the sort of people that, you know, wanted to come to the sort of therapist they thought I was. And it -- a lot of the work had already --	The right' fit'
97. Yeah.	
98. P.2 -- been done, you know. It's -- it -- it -- it was really quite useful in terms of fit.	
99. P.2 Fit and perhaps --	
100. Mmm.	
101. P.2 -- feeling safe.	
102. P.2 Yeah. Yes. Just to, you know --	
103. P.2 But that's -- that's only one -- you know, that's only one side.	
104. Yeah.	
105. P.2 That's on the internet --	
106. Yeah.	
107. P.1 – so people are able to kind of start the alliance if you like before they actually meet you and speak to you.	Pre-therapy expectations
108. Mmhmm.	

109. P.7 But as we say in other settings, um you know, it's not until you actually invite them into the room that they actually know who you are.	Rawness
110. Mmhmm.	
111. P.3 So then obviously it -- it -- it starts from -- from that point.	Emergence of the TA
112. Yeah.	
113. P.6 I would say that the people I see who have never seen me -- looked at the internet or anything --	More exposed
114. Yeah.	
115. –P.6 are more nervous initially --	Client anxiousness - coping
116. Mmm.	
117. Mmm.	
118. P.6--than the people who come to me privately.	Levels of emotion /reactions
119. Mmhmm.	
120. P.6 So it's like __ --	
121. P.4 No -- you know, no. I don't know that I would say that.	Different experiences by different therapists
122. Mmhmm.	
123. P.4 I don't know.	
124. [laughter]	
125. P.1 Just out of curiosity, at what point do you think they might start with this questionnaire? Halfway through the therapy, at the beginning of the therapy?	Exploring
126. P.7 What do you mean? Who would start with it?	Unsure
127. P.1 Well, the --	
128. P.1 The therapist?	
129. P.1 --yes. I'm just kind of looking through some of the questions here. And I'm just wondering at what point --	Introducing an objective measure of the TA
130. P.3 I know I would -- I would never use a document like that in there.	Self-sufficient Resistance
131. No.	
132. P.3 I think that on there that, you know, as a -- as -- the type of therapy I do, I wouldn't even, you know -- it says I'm confident in my ability to help. And I find that word help uh -- you know, it makes it sound as if I've got some kind	Overpowering concept

of power that I can do something for that person. And I -- you know, that per--	
133. Mmhmm.	
134. P.3 -- you know, that doesn't fit very comfortably with me.	Uneasiness
135. P.3 Having worked in two very different settings now -- counseling -- one where you would get out the occasional piece of paper and -- and do that in a client friendly way as you could possibly explaining and trying to, you know, empower them and everything else. And now moving to one where there's no paper, um I -- clients have commented to me that they really, really like that. That there is no paper involved.	Therapeutic dynamics different
136. Mmhmm.	
137. P.3 That they don't see me as they have seen other professionals with the image of that professional. And that has helped definitely the relationship --	More personal than professional engagement.
138. Mmhmm.	
139. P.3 the alliance, the bond.	
140. P.2 I would agree with that 'cause I find sometimes that handing questionnaires out at the beginning of the session, sometimes people just want to talk and they -- they've got so much that they've been building up --	Measures get in the way
141. Mmhmm.	
142. P.2 -- and you present them with paper and then you need to check out that they're actually comfortable with filling in forms.	Clarity
143. Mmhmm. Yeah.	
144. P.2 Uh because that can put them at a disadvantage immediately if -- if they're not.	Inequality
145. P.4 They might not be able to.	
146. Yeah.	
147. P.4 Do you not do any information gathering that's written down at all?	Style and process
148. P.3Yes. I do do information gathering.	
149. Mmm.	
150. P.3 Um well, two very different settings. Um but in each setting, there'd always be a basic level of information there. So I'm quite lucky in some respects. An initial information gathering would have been done --	Different settings require different things
151. Okay.	

152. P.4 -- for me. Um not in both cases, but in -- in the latter case. So -- but ev-- even um, you know, the gathering information process -- I guess in truth I do have a slight structure in my head. I know the things I want out of that first session, which sounds like what I want and not what the client wants. Some of it is -- I should say probably 40%, 50% is what the client wants to talk about, wants to unload. But I definitely have a structure of things that I also want out of that session, um which was gui-- I was guided by -- by my supervisor on that. Um and also for safety parameters, which of course includes contracting. Really important.	Structuring the process Meeting client need Being flexible Professional boundaries, ethics
153. Mmm.	
154. P.5 I'm just wondering whether actually the information and the form gathering at the beginning of a session and getting some feedback is -- is part of where that alliance starts.	Relationship building
155. Mmhmm.	
156. P.5 And where the sort of building blocks of a relationship between two people that uh, you know, you're both there. Like you say, somebody can be quite nervous when they come in. So initially having this sort of structured part of the session gives you both a chance to sort of check each other out to see how each other are feeling. Whether -- having that structure actually does help the alliance form.	Testing the water on both sides
157. P.7 So it could go both ways.	Different opinions on need
158. Mmm. Mmhmm.	
159. Yeah.	
160. Or --	
161. P.7 I can understand that.	
162. –P.3 -or the opposite. It could put somebody --	Adverse to formality
163. P.3 I definitely find that -- I -- I've always used um -- you know, a form that I dev-- but I used to work for …….so it's sort of loosely similar to what I used there.	Familiarity makes information gathering easier
164. Mmhmm.	
165. P.3 And it's just basic information about sort of -- address and --	Personal detail checking
166. Mmhmm.	
167. P.3 -- whether they're married or got children, how old the children are --	Family history
168. Mmm.	
169. –P.2 -and health. Any health issues, any medication. And um -- at the end, I do birth	Demographics –Geno-gram

family -- who's in your birth family. S-- siblings and are your parents alive, which -- and -- or divorced. And that tells you quite a lot.	
170. Yeah.	
171. P.2 You know, that can open out quite a lot of ___.	Treading carefully at the outset Carefulness
172. [coughs]	
173. P.2 And it's quite short. And I -- I make sure it -- it doesn't sort of dominate the session.	Style that's less burdensome
174. Mmhmm.	
175. P.6 But it does -- it does -- I don't know. I feel -- I've just kept on doing that 'cause it feels quite comfortable for me --	Developed own style that feel comfortable -safety
176. [coughs]	
177. P.6 --and the client. It's sort of like reassuring I think. It's a bit professional that you've got [laughs] --	Structure reflects professionalism
178. [yawns]	
179. P.6 --you know, you've got that bit of structure.	Personal re-assurance on structure
180. P.7 So it's having direction --	Leading somewhere
181. And um -- yes.	
182. P.7 A bit of direction without being direct.	The way ahead but agreed
183. P.7 But it's kind of open.	Opens up the process
184. [coughs]	
185. P.7 They can chat and talk as they're doing it. And --	Amenable less formal Facilitating a safe environment
186. Mmhmm.	
187. P.7-- sometimes you know, bits of information about health or family lead onto --	Pre-information
188. So it's a bit like an assessment really, isn't it?	Gathering information
189. Slight-- yeah.	
190. Yeah.	
191. P.7 But very informal and --	
192. Yeah. Yeah.	
193. P.7 So you can kind of build up a bit of a framework of what's happening with the client.	Formulation
194. Yeah.	

195. Yeah.	
196. P.6 Um I do somewhat --	
197. [coughs]	
198. P.6 --with like drug users. And it's a bit like that. You know, you can get a history of their kind of drug use and --	Background information
199. Yeah.	
200. P.6 -- their offending and their family. And it gives you a framework of where to start from.	Sets the scene
201. P.4 Of course.	
202. P.6 I generally find that they actually find that quite helpful themselves as well.	Amenable
203. Yeah.	
204. Yeah.	
205. P.6 It kind of -- you know ___ --	
206. ____.	
207. P.5 As for a while, I had to use those core forms. Is it core?	Reflection on previous /current practice
208. Yes.	
209. P.5 For ___ ___. And there were so many forms and I really felt they got in the way. You know, just too -- took too much time in the initial session. And it's important for me with the therapeutic alliance to feel that I've -- in that first session, made people feel -- kind of feel at ease and um comfortable and safe. And then got some preliminary information and -- and then done a little bit of work so that they've kind of got a flavour of well, this could actually, you know, make a bit of a difference to me.	Obstacle in the room Initial tasks Ethics Balance Insight into the process
210. Yeah.	
211. P.5 You know, that they come in feeling one thing and then go out with just a little bit of shift in some way.	Client development Different perspective
212. P.3 And -- and a little bit of hope maybe.	Hope
213. Yeah.	
214. P.4 I think it's important to build hope right in the first session.	Task influencing motivation
215. P.3 I think so, too. And in fact, those first few sessions --	
216. Mmm.	
217. P.3-- building up the therapeutic alliance I -- I	Importance of early alliance

think are essential.	development
218. P.1 Would you use the word hope or would you use the word confident?	Definitions attached to supporting self-motivation
219. P.3 Uh pff. I think it depends on what every person wants to take away from it. But what I would say is I think something has to come from those first few sessions. Um you know, things like trust don't happen immediately. Of course, they don't. They take a while to build up. It strikes me with some clients I've seen, it's more about them seeing if they can accept me as a person -- as a person that they want to work with. I think that it important to some of my clients.	Early progress in the relationship to establish trust Client preference of therapist
220. P.3 I probably would use hope actually.	
221. P.1 You would.	
222. Mmm.	
223. P.4 I'd probably use potential. The potential for change, their potential for things to be different by ___. But I -- I think I would agree with…… in the sense -- sorry -- I think I would agree in the sense that um, for me, the relationship is about us being accepted as -- that being perceived by the client as a counselor they would want to interact with.	Envisaged potential of the relationship and work
224. Mmhmm.	
225. P.7 But I also actually think it's about -- for me, one of the foundations of the therapeutic alliance is acceptance of the person sat in front of me.	Acceptance of the client
226. Mmhmm.	
227. P.3 So I think my acceptance of the client --	
228. [coughs]	
229. –P.3 -is a f-- is a fundamental building block.	Grounding of the relationship
230. P.3 And showing that acceptance.	Acknowledging acceptance
231. Yeah.	
232. So --	
233. P.3 in a congruent kind of --	Therapist honesty
234. -- in a --	
235. P.1--genuine way.	Therapist genuineness
236. P. 3-absolutely. Being real --	Therapist, the real person
237. Mmm.	
238. P.6 -- in that. I -- I think that's one of the key ways I've found that people have come back to the next session. They know or hopefully you've	Acceptance of the therapist.

-- some people are -- some people don't. But you've gone over a basic level of what your qualifications are -- mmm -- who you're a member of. And then um you know, from that, you know, showing their acceptance of you --	Professional validity
239. Mmm.	
240. P.6 -- by coming back to sessions and --	
241. P.5 It -- qualification bit and all of that for me again is something that I wouldn't necessarily [sighs] potentially on the internet, somebody could explore that, but it -- for me, it's very much if about the state of being. I am very much the way I am so the qualification part and the kind of credibility part --	Being a person/and not just a professional
242. Oh, yes.	
243. P.5 -- is important, but I wouldn't necessarily see that as -- as part of that alliance. That might --	
244. Right.	
245. P.5 -- come with confidence and ability, but um --	
246. Mmm.	
247. P.5 --that wouldn't be something I would discuss.	
248. P.4 For me, there's definitely two parts. There's me, the real me that's really important that I bring to that session. And if I'm anything else, the client's going to see straight through it. And that's the bit I feel they really accept and get in tune with. Um however, the other part of me is, you know, I do have a um -- I do have a, you know, an ethical framework. I work __ an organization.	Brings professional and personal self - two hat position
249. Mmm.	
250. P.5 Um and now I do share that with the client.	
251. P.7 What do you think might get in the way of the therapeutic relationship? Just out of curiosity. If you think over experiences where you feel that's --	Therapist exploring experiences of other therapists
252. P.5 If a client felt that you judged them or that, you know, so --	
253. P.7 Okay.	
254. –P.5- that would definitely -- um some people um feel quite judged in life so are quite sensitive to it. So if they felt that you were judging them in some way, um that would definitely probably be very damaging to the therapeutic alliance, wouldn't it?	Harm

255. P.2 I was told by a client once that I was trying to rush them to the goal. And rather than being stood next to them, I was in front of them pulling them along.	Therapist's own agenda Ahead of client
256. P.4 So you were pulling them?	
257. P.4 Interesting.	
258. P.2 Yes. And I -- and that was really --	
259. P.2 Mmm.	
260. –P.2 -really good.	Challenges
261. P.2 Mmm.	
262. P.2 Well, that -- I -- she could reflect that back, but then obviously we talked about it --	Overcoming ruptures
263. P.2 And I guess sometimes if you're doing uh, you know, I mean obviously if you're in private practice, you can kind of make your own kind of rules and agreements about how long or short therapy is. Obviously in some places, there's a lot of pressure --	Brief therapy can create pressures
264. Mmhmm.	
265. P.2 --to do short-term work. So --	
266. P.4 Absolutely.	
267. –P.4 - there is possibly more of a danger of trying to [laughs] whiz somebody from A to B because --	Ethics and maintaining need
268. Mmhmm.	
269. P.4- obviously you've only got a limited amount of time --	
270. Mmhmm.	
271. Yeah.	
272. P.6 --or you may not in that space of those sessions feel it appropriate to allow them to open up on some points 'cause there's not time in that six weeks for ethically to be safe to do that.	Restrictive practice Client protection
273. P.4 Absolutely.	
274. So they could feel quite rushed. Yeah. No. Yeah.	Preventing harm
275. Yeah.	
276. 'P.2 Cause I -- I would say with the six-week kind of brief interventioning as well, from my experience, it's sessions three or four that there's normally a shift in the relationship. I would say that's when it would, for me, the con- the therapy alliance becomes more concreted potentially on session three or four, which if you're working a six-session model, then kind of	TA development Longer term work is best

you get a peek, and then it's kind of building to end, which I find more difficult, whereas on long-term work, it's different.	
277. Mmhmm.	
278. P.1 I was just interested to see how you reacted when she said that to you. How did you -- how did it progress from then that she said -- obviously that was being quite honest with you. And --	Reflecting on potential ruptures or challenges in therapy Therapist congruence appreciated
279. P.2 Oh, absolutely.	
280. P.1 -- ___ to me I think I would have felt sort of quite criticized myself about the way I practice.	Therapist self-esteem
281. P.2 Oh, it was -- yeah. ____ to start. I'm not going to say I -- I was feeling great --	Overcoming ruptures -fall before the rise
282. [laughs] Yeah.	
283. P.2 --about it. But we had developed such a relationship by that point -- 'cause this was a long-term --	Relationship strength
284. Mmm.	
285. P.2 -- um client -- that we had that ability --	Trust developed
286. Yeah.	
287. P.2-- uh and -- so yeah. It was really useful. And I just -- we just then said afterwards am I pulling, pushing or by your side?	Supported relationship -lessons learnt
288. Mmm.	
289. Yeah.	
290. P.2 And even now, we'll comment about that.	Rupture effective
291. Yeah.	
292. P.3 So it was actually really useful.	
293. P.1 So it has enabled -- her honesty enabled the process almost as though it might have deepened a bit more or became --	Deepened the relationship
294. P.2 It did.	
295. -- yeah.	
296. YP.1 our response to that could have made a br-- you know, a make or break kind of therapy --	Fine line on making or breaking therapy
297. Yeah.	
298. –P.1 - couldn't it?	
299. P.2 -Absolutely.	

300. P.1 If you'd made the wrong response --	
301. Mmm.	
302. P.1 -- that could have --	
303. Mmm.	
304. P.2 Yeah. I mean I apologized for it --	Integrity
305. Mmm.	
306. P.2 -- because I think that was an honest thing to do.	Sincerity
307. Mmm.	
308. Mmm.	
309. P.2 That getting along side is -- is really important , isn't it?	Work with, not ahead
310. Yeah.	
311. Mmm.	
312. P.4 Um so that the -- the client really feels sort of -- that they're not being [laughs] pulled or pushed or taken anywhere by you. That they can be themselves --	Client empowerment
313. [sighs]	
314. P.4 - and that you're sort of there, but you're not interfering. You're just letting them have their process and be who they are. And you're really recognising that and kind of intuiting where they're at.	Free will Autonomy
315. P.2 That's a bit what I meant about when it comes to the helping 'cause I think if you're helping, you're kind of directing someone. Almost what it feels to me.	Facilitating opportunities for empowerment.
316. Mmhmm.	
317. Mmm.	
318. P.6 I would never use the word helping --	Help is disabling
319. F: P.6 No.	
320. -- in -- in -- in --	
321. Yeah.	
322. P.6 -- in counselling.	
323. P.6 It's a bit patronizing, isn't it?	
324. Yeah.	
325. It is.	

326. P.5 But also if you're linking in to the ethical framework, then the autonomy of allowing them to be --	Ethics leading to empowerment
327. Mmm.	
328. –P.5 - kind of self-governing and --	
329. Yeah, yeah.	
330. P.6 - again linking with the helping thing --	
331. P.6 No. I've not helped ever -- I've -- I've worked in jobs where I've been a help -- you know, in -- in -- in --in a support role or a, you know -- and it's an entirely --	Therapists are not support workers
332. Mmhmm.	
333. P.3 -- absolutely entirely different thing.	Therapeutic relationship different to other professional relationships
334. Mmm.	
335. P.6 I'm not there to help people. I'm there to helpful-- you know, and -- and for them to facilitate helping themselves really.	Facilitator
336. Mmm. Mmm.	
337. P.2 I think my um predominant model that I work with is CBT, which is very structured.	CBT Needs Directive Approach
338. Yeah.	
339. P.2 And as I -- I was trained person-centered. And then I've gone on to do CBT. And -- and that's where sometimes I'm ahead --	Approach guides therapist
340. Mmm.	
341. P.2 -- of the client --	
342. Mmhmm.	
343. P.2 --because that's the goal we've set so let's achieve the goal.	Need to facilitate how goals achieved
344. Mmhmm.	
345. Mmm.	
346. P.2 And -- and -- and that can become a problem with a therapeutic alliance.	Therapeutic alliance built on collaboration not therapist led
347. Mmm.	
348. P.2 And see I find actually naturally myself, I like to work that way myself. If I have a problem or I have things going on, I like to work to goals and get it done and -- and move quite quickly. So I find I naturally -- I have to be very aware when I'm working with somebody that that -- if that's not what they --	Taking control, but for the good of getting goals achieved. Still aware of the client's needs

349. Yeah.	
350. P.2 -- choose to do, I have to be more patient myself.	Careful about own agenda over the client's
351. Mmm.	
352. P.2 And I think I probably do work better with people that have a similar way of working that I do because obviously we're working I suppose at the same speed and the same -- in the same, similar way.	Parallel process with client and therapist working at same pace
353. Yeah.	
354. Mmm.	
355. P.2 So thinking about it, I probably do tend to have better sessions with people that are actually more in tune with the way I want to work --	Compliant client more productive
356. Mmm.	
357. P.2 -- and the way I do things.	
358. P.2 I mean not everybody has a goal or they probably have, but they're not able to -- or they're not searching or not --	Need for direction on times
359. Mmm.	
360. P.2 -- able to verbalize it.	Clients not always able to explain what they need
361. Mmm.	
362. P.2 You know, they know something's not right or they're not happy or they want things to change, but to actually specify --	
363. Mmm.	
364. –P.2 - a particular goal, they may find very, very difficult.	Hard for clients to know what they want
365. P.3 Yeah. I think what's most important uh for me in my relationship with clients is encouraging them to really, really trust their own sense of themselves and their own feelings. So I just keep putting it back to them. What do you feel? You know, what -- in your body, what do you feel about that? And you know, refuse to be drawn on, you know, what do you think or, you know -- it's -- it's kind of what's your sense of yourself? Because they're -- you know, that's what's, to me, is going to help the most in their life. To have confidence in that --	Facilitating opportunity for autonomy, empowerment, self esteem, self-worth Being mindful about own needs
366. ____.	
367. P.3 --inner sense of themselves. Yeah. And be -- and be able to be guided by their own experience and sense of themselves. Feelings. So um -- yeah.	Self direction

368. P.7 So would you say then part of that therapeutic alliance is that you having confidence in their ability gives them --	Therapists belief on clients
369. P.3 Yeah.	
370. P.3 -confidence in their ability?	
371. P.3 Yes. Yes.	
372. P.3 That makes sense.	
373. Yes.	
374. P.2 Yeah. 'Cause if they asked you what you think and you told them what you think, it's taken the autonomy away.	Disempowerment
375. Mmm.	
376. P.2 Whereas if they're --	
377. Yeah.	
378. –P.2- if I've got confidence --	
379. Yeah.	
380. P.2-- in you that you have the skills within your --	Resourcefulness
381. P.6 I had a client I worked with him for about like six months. And he -- in the beginning especially, and then it became a bit of a joke, but he kept asking me what I think.	Awareness of low self esteem
382. Yes.	
383. P.6 You know, and I'd say well, no --	
384. Yes. [laughs]	
385. P.6 -- I know what I think, but what do you think? You know?	Self-esteem building
386. Mmhmm.	
387. P.6 And then he -- and he would always answer. But it's like well, you say you don't know really what the answer --	Projection
388. Mmm.	
389. P.6 -- and then in the end it became kind -- he'd go what do you -- you know [laughs] it would become a bit of a joke.	
390. Mmm.	
391. P.6 It was almost like he was asking you --	
392. Yeah!	
393. P.6 to invite him what he thought.	

394. P.6 Yes. And they do -- you know, people can -- they do know what they --	
395. P.6 They see you as the expert and they project that onto you.	Therapist expert
396. Yeah.	
397. P.6 And it's giving away their own power --	Client self-Disempowerment
398. Yeah.	
399. P.6 --and their own confidence in themselves.	Lowering self worth
400. P.5 Yeah. I think power is really important in that room. Um I found with some clients that I'm working with now 'cause -- because they're coming feeling very dis-- disempowered. Sometimes to equal up, I find I get the beanbags out and I make myself a little bit lower than them.	Implicit dynamics on achieving equality Therapist aware not superior
401. Mmm.	
402. P.5 And that actually shifts the dynamic in the room --	Creates equilibrium
403. Mmm.	
404. --quite a lot.	
405. Yeah.	
406. P.5 It just does, which is quite interesting.	
407. [laughs]	
408. P.4 So if I feel they feel that way --	
409. Mmhmm.	
410. –P.4 - I make myself a little bit lower.	
411. Mmm. Mmm.	
412. P.2 The best work I did was with a client who -- we'd been struggling for weeks. And in the end, we both got on the floor and sat with our back against the wall and we didn't look at each other.	Meeting the client's need at any level Creative Less threatening
413. [laughs]	
414. P.2 So it really -- so shifting -- it's totally not looking at each other.	
415. Yep.	
416. P.1 That's amazing, isn't it?	
417. P.2 Yeah. And that really works. And that's when the alliance started to work with us.	Acknowledging the client's distress, Changing the dynamics in the room helped develop the TA

418. P.2 That's when the alliance started to work.	
419. Yes.	
420. P.7 So what was it about that? What was it about that that allowed the alliance to work -- the bond to start forming?	Bond –relationship building
421. P.2 It was I think both of us really on the floor.	Un-inhibiting
422. P.1 Both of you on the floor --	
423. P.2 Yep.	
424. P.1 -- in the same position.	Equal status
425. P.2 And she said it was because I wasn't looking at her.	Less threatening
426. P.3 Right.	
427. P.3 There's an openness in that, isn't there? A creativity or --	Opened up a process that was essential avoidant
428. Mmm.	
429. P.2 -- receptive to that particular person and what they need --	Beneficence
430. Yeah.	
431. P.2 -- and other things hadn't worked and you were open to the possibility of doing something quite unusual [laughs] --	Being flexible creative
432. Yes.	
433. P.1 Sitting on the floor with your back --	
434. Yeah.	
435. –P.1 - back to the wall.	
436. Yeah.	
437. P.2 And then she really started to talk.	Practice less threatening
438. Mmm.	
439. Yeah.	
440. Mmm.	
441. P.1 So all the training we do about eye contact and uh -- and body language --	Non verbal communication
442. P.2 I tried all that.	
443. P.1 -- the positions of the chairs and everything. It sounds like in your case, that wasn't necessarily --	Ergonomics
444. P.2 With that particular client. But then that's -- that's part of our assessment. That's what we're	Appraising the needs of the individual

looking for, isn't it?	
445. Mmm.	
446. Mmm.	
447. P.1 Individuality.	
448. Yeah.	
449. Yeah.	
450. P.4 To see how they would prefer to work with you.	Client's perspective
451. Mmm.	
452. P.2 And that might be where -- where a person starts from or, you know -- I worked with someone -- I think I worked with them for over a year. And when they first came, the first thing they did when they came in the room was to turn the chair away from me?	Client needs to feel less threatened
453. Mmm.	
454. Mmm.	
455. P.2 Uh, you know, and that's where that person was at that time.	
456. Mmm.	
457. P.2 And it's about just accepting that and accepting them.	Non judgmental -acceptance
458. Mmm.	
459. Yeah.	
460. P.2 And -- and you just work with that and, you know -- by the time we got to the end, you know, he used to sit and face me and be very relaxed and quite comfortable.	Client's achieved growth and trust in therapist through own pace
461. Mmm.	
462. P.2 But it took a l-- it took a very -- it took a very, very long time --	Patience –meeting client need
463. Mmm.	
464. P.2 --for that to happen.	
465. P.7 So one of those limitations possibly is time.	Client's needs not always containable limited sessions
466. Yeah.	
467. P.7 ___ time and limitations for the therapeutic alliance is actually --	
468. P.2 Mmm. Well, I think that -- that's where ethics come in because I suppose if you -- if you uh were working in a setting and they only allow	Balancing ethics and respect for individual need

six weeks and you had a client who, when you did your assessment --	
469. Mmm.	
470. P.4 had a lot of issues, the -- you know, that you -- you would know would not fit into a six-week model, then it would be unethical really to take that client.	Protecting clients –Beneficence
471. Mmm.	
472. P.6 Um they need to go and be passed on to -- be referred on.	
473. P.1To re-	
474. P.1 So that's also --	
475. P.1 availability of having the opportunity --	
476. Mmm.	
477. P.1 to build that relationship knowing on assessment.	
478. P.2 Yeah.	
479. P.2 that actually it was a long-term piece of work --	Using judgment to meet client need
480. P.2 Yeah.	
481. P.2 rather than short-term.	
482. P.2 You would have to know you could offer -- you know, it -- it would be unethical, wouldn't it, to offer --	Need for boundaries for client protection
483. P.1 Would it be unethical if you were very honest with them and explained okay, within this, is there something specific that you would like to work on --	Identify client expectations with service limitations Compatibility with the service over the therapist
484. P.2 Well, yeah. It depends on what the person -- yeah. It depends on what the person wants to get out of the therapy. And you would have to pass that to --	Client expectations and self decision-making
485. P.2 Pass it back to them --	
486. Yeah.	
487. P.2 to give them the choice and the option. 'Cause I've made that presumption in the past, but actually some people would rather have six weeks knowing they want to be with you in those six weeks and work on something smaller --	Autonomy Priorities of need
488. Yeah.	
489. than -- than not.	

490. P.2 Yeah. It depends on what they're coming with.	Evaluate situation at assessment
491. Sure.	
492. P.4 Yeah. But yeah, you would have to say to them that we've only got six weeks so, you know --	Openness
493. ___.	
494. P.4 -- that there would be things that it would be wrong to open. I suppose that's what I meant. Things that would be wrong to open for a person.	Assurance of meeting client need
495. P.7 And yet how do you -- how do you -- sometimes that's really difficult to manage though, isn't it? If somebody wants to talk about something that's their overriding need, and you've explained the boundaries, the safety issues, how far you can work with somebody. And they still want to go ahead -- whoo. I don't know.	Managing systems and process. Time management Structure
496. P.4 Well, as a therapist, you could say if you felt it was not safe to do that, you -- you could still say no.	Ethics on boundaries Contracting with client Informed consent
497. Mmm.	
498. P.5 But that would be -- it -- you would be using your own experience and judgment on that.	Therapist judgment in offering safe practice
499. Yeah.	
500. P.6 I think from my perspective, I find with certain clients that it comes back to one issue. So even if we're --	
501. Yeah.	
502. P.6 -- looking at a little bit of -- say it's um anxiety or something like that, it might come back to a core issue --	May be working on less important matters under time-limited conditions
503. Core.	
504. P.6 -- that actually has lots of different things.	
505. Mmm.	
506. P.6 And I think when -- with the therapeutic alliance or relationship side of it, it's linked to them wanting to come back to that core. There's a trust --	Deepening the process to meet client need Fidelity
507. Mmm.	
508. Mmhmm.	
509. P.3-- with coming back to it. There's a safety.	

510. Mmm.	
511. P.3__ facilitated kind of actually I feel safe enough in here to talk about that with you.	Beneficence and non-maleficence
512. It comes --	
513. P.1 This one's -- sorry. I just wanted to get back to something that you said about um con-- having confidence in the client to grow themselves or sort out their own problems.	Clarification re-checking meaning
514. Mmhmm.	
515. P.1 I was just wondering is there any times where you don't have that confidence and whether that makes a difference to the relationship? If you yourself don't feel they're able or don't feel they're -- you don't feel that confidence that they can actually make changes or they're not in a position to make changes, does that affect how the relationship develops?	Therapist's responses, belief in the client How does this affect the TA and relationship
516. P.3 I can't think of anyone that I would work in a different way with.	
517. Mmm.	
518. P.3 I would always have confidence that in each person, there's a --	Therapist belief in client, integral to process
519. Mmm.	
520. P.3 -- there's a -- an ability to be in touch with -- get in touch with what they feel. However confused or dysfunctional their life is --	
521. Mmm.	
522. P.3 -- or their experience is. In that confusion, if they can kind of be with that confusion, things start to come out --	Being empathic to varying levels of need
523. Mmhmm.	
524. P.3 -- from it. You know, it's different aspects of -- of their exp-- feelings.	
525. Mmm.	
526. P.3 You know, somebody may talk about themselves, you know, I'm just depressed. Depression to me is just a word. And within that, there are so many different feelings.	Exploration of inner meanings, implicit messages
527. Mmm.	
528. P.3 And you know, the experience to begin with of -- of the person might be just this sort of weight of depression and being completely stuck in that. But you know, it -- with all of those -- every feeling, there are so many parts, so many aspects. And you just start to pay attention and --	Unpacking the problem, and doing this sensitively to provide the client with time and space to articulate feelings and thoughts

529. Mmm.	
530. –P.3 - encourage that person to be with their own feelings and -- and it starts to flow, you know, and unfold.	Free flowing
531. P.1 So it sounds like -- I remember I came -- when I came in, somebody was talking about hope and that sounds very much --	
532. Mmm.	
533. –P.1 - like you're saying that you see hope in that person. Some sense of -- something that's there. A belief or hope --	Therapists' belief in the client
534. P.3 Yes. Always.	
535. P.1 and they can change.	
536. P.3 Yes.	
537. P.1 So that's -- that sounds like a good start --	
538. P.3 The most sort of dysfunctional people -- you know, the most extreme sort of situations --	
539. Mmm.	
540. P.3 -- seem to be able to, you know, come to very different places.	
541. P.3 Like accessing resources. Everybody will have had some experience of success in their life at some point.	Drawing on inner resources. Self-esteem building
542. Mmm. Yeah.	
543. P.3 No matter how small it is.	
544. Yes.	
545. Mmhmm.	
546. Yeah.	
547. And --	
548. P.3 Resources are so [laughs] important.	
549. P.3 They can feel good about ___.	
550. Yes.	
551. P.1 That might help them to --	
552. P.1 To build on that. Whatever little --	Staged process in making progress
553. P. 1 So do you think we as therapists then have to have some sense of hope for our clients then? Do we have to start that process off by having this sense that there is hope or there is some sense of --	Therapist's contribution

554. P.1 I think --	
555. P.1--beginning or something? Is that how it starts?	
556. P.3 I kind of interpret it a little bit of us having faith.	Belief in the client and process
557. Mmm.	
558. P.1 So rather than having hope --	
559. Mmm.	
560. Yeah.	
561. P.1 -- having faith.	
562. Yeah.	
563. P.3 There is -- they have the potential.	
564. Yeah.	
565. P.4 So do you --	
566. P.4 It's sort of trust, isn't it?	
567. Yeah.	
568. P.3 Trust in the process.	
569. P.3 It's -- it's um -- it's a bit like we talk about conscious -- what's there, what's obvious, what we collect in our information gathering --	Sharing explicit information to support process
570. Mmm.	
571. P.3- and then moving on to the other stuff. Maybe the unconscious stuff. And then almost below that, sort of like the emotional depth for me is like the essence -- the leap of faith of that person. And how that reacts with you as well and vice-a-versa.	Explicit information leads to implicit information Deepening the process scary for both, but needs to be done
572. Mmm.	
573. Yeah.	
574. P.3 And in fact the more they're willing to explore, the more the willing they are to go there, it -- I think that deepens --	Test the waters
575. P.3 Or sometimes not willing to go there actually.	Not ready. Needs to climatise within the environment
576. P.7 Mmm. Mmm. So the respect's the same -- that they're -	
577. P.7 For them as a person, the essence of them -- the spirituality of them --	Deepening the process can become spiritually engaging
578. Mmm.	
579. P.7 I think when I talk about hope, it's about	Helping to develop self-confidence in

building hope in the patient. That things can be different.	the client
580. Mmm.	
581. P.1 So they need to leave that first session --	
582. I feel that --	
583. P.1 --having that hope that -- yeah.	Noticeable change occurring
584. P.3 Yeah. For me, like I said, I think for me, potential. So it's same logic -	
585. [laughs]	
586. -- different --	
587. Okay.	
588. P.3--different framing probably.	
589. P.3 I feel that, too. I feel there's -- the first session -- those first couple of two sessions are so important in the process of building up the alliance. That we generate that feeling of potential or leaps of faith --	Early attachment for alliance building
590. Mmm.	
591. P.3-- or hope. Just something --	
592. P.4 Planting a seed.	
593. –P.3- yeah. Exactly.	
594. P.6 But do we have to feel that as well do you think to make it work? I mean if you -- I can't think of anybody at the moment where there's somebody that you worked with that you actually think they aren't going to change. There's no way this process --	Against all odds.
595. I have --	
596. P.6 I have had. I have worked -- I have worked with a client that I thought, you know, she -- real -- really difficult kind --	Client's resistance to engage Threatening environment –lack of trust.
597. Mmm.	
598. P.6 Um and she was an alcoholic so um -- and -- and -- and I -- I -- I didn't -- I didn't think we were going to um get --	
599. ___yeah.	
600. --anywhere.	
601. Yeah.	
602. P.5 Get an outcome for her. I didn't -- I -- I just didn't think it. And I still sometimes, I'm absolutely astounded -- I don't know how we did, but after six months, she went to rehab. And	Therapeutic alliance evolved experientially rather than through conscious structure

she had to not drink for seven days, and -- and I mean I can't tell you how horrendous that was to --	
603. Mmm.	
604. P.6-- they won't take you in rehab if you've been -- if you've had a drink in the last seven days. And -- and she -- she made it. And I -- to be honest, I didn't think she would. She was so bad.	
605. P.7 But yet you were still able to work with her --	Unconditional positive regard
606. P.6 Yeah.	
607. P.7 ___ to work with her.	
608. P.6 It was about accepting -- she came and -- and she wanted to and I just took each session as, you know --	
609. Mmm. Mmhmm.	
610. P.6 -- but I didn't -- no. I didn't think we -- I didn't think --	
611. P.7 So acceptance again sounds like quite a key.	Acceptance
612. P.7 Acceptance.	
613. P.6 Accepting somebody for what they are.	
614. I P.6 -- I just -- you know, she managed to get here. In whatever state she was in, she managed to get there. And sometimes she was pretty bad, but I never thought we'd get --	
615. [laughs]	
616. P.6 -- yeah. But we did.	
617. P.6 I think timing is an issue as well 'cause I -- from my experiences, people are sent to ___ there are people that access -- that -- that actually seek out --	Client free-will
618. Mmm.	
619. P.6 -- and the relationship can be affected in -- I think in those early stages. If someone's not ready --	
620. Mmm.	
621. P.6 -- if they're not in a place where they feel they're ready rather than someone sent them --	Autonomy important
622. Yeah.	
623. P.6 -- I think that can affect the relationship as well. The dynamic --	

624. Mmm.	
625. Yeah.	
626. P.6-- and the acceptance that they've been sent.	Client readiness
627. Mmm.	
628. Yeah.	
629. P.6 That -- again that kind of honesty part --	
630. Yeah.	
631. Yeah.	
632. P.6 -- but inviting the honesty.	Providing a safe environment
633. Mmm.	
634. P.6 And -- 'cause I've had uh in the early stages, relationships with people of ___ and the hostility is there.	
635. Mmm.	
636. P.6 The hostility for whoever sent them [laughs] or where their situation has been directed in a different way --	
637. Mmm.	
638. P.6 -- and acknowledging that and --	
639. Mmm.	
640. -- and that kind of thing so I think the timing is a big issue. She obviously -- that person wanted to come. She --	Client readiness to engage
641. P.6 However -- however difficult everything was --	
642. Mmm.	
643. P.6 -- and that was horrendous, but somewhere inside her, she wanted --	
644. P.6 Commitment. She was committed.	Commitment on both parts
645. P.6 -- you know, and -- and so however hard the struggle was, she -- she made it. I mean some therapists may have refused to have seen her 'cause sometimes she wouldn't come [laughs] in a very good state. And some people have got rules, haven't they?	Unconditional positive regard, faith in the client's willingness and attitude to make change
646. Yeah.	
647. P.6 But I just think if they'll come --	
648. Mmm.	
649. –P.6 - I'll see them. May not actually complete the counseling session 'cause they may not be in	Empathic Acknowledging human distress and the need to validate that

a fit state, but I would still speak to them and see them.	distress
650. P.6 So that's part of that relationship building --	
651. P.6 It's about accepting the person. Accepting the person. But you may -- you know, I've said to her, you know, we won't be able to do any therapy today because of [laughs] how you are.	Facing challenges but yet managing them appropriately and ethically
652. P.6 But that to me is very accepting --	
653. P.6 But it's accepting the person and not shutting the door and saying --	
654. Yeah.	
655. P.6 -- actually you know, you can't come in today, you know. So yeah. Acceptance. Huge.	
656. P.5 Um so perhaps you were also talking about flexibility as well? Knowing that you -- I mean I don't know, but my perception is flexibility can be -- must be really important in forming the therapeutic alliance --	Flexibility In the real world nothing is perfect
657. Yeah.	
658. P.6 -- for me anyway. And sometimes I -- I think I find myself questioning, you know, am I doing the right things as a counselor? And I take it in to my supervisor who says well, you know, um is -- there isn't a right thing. Did it feel right? You know, sometimes I find myself putting on different hats --	Reflexivity Sharing responsibility Self-evaluation
659. Yeah.	
660. –P.6- um and very often, I have certain clients who won't come in on time um especially you know --	
661. P.7Yeah. But how do you feel then -- how do you get that sense that it has been successful? And that you have --	
662. P.6 Well, sometimes um I can do it very -- this sounds really bland, but I'm going to say it anyway -- very numerically. For example, there may be key iss-- key issues um -- uh that uh -- well, I know there are shades of greys in-between the numbers. For example, if their key areas I'm working with -- I've been working with somebody for 33 weeks now, which is a complete luxury 'cause I was used to working with people for six weeks. Um well, I say luxury. Perhaps not, but um 33 weeks. And core issues, you know, like self-esteem. She called her nervous breakdowns her angry outbursts. Intimacy. All of those things. We start at the beginning of where was she? How low was she on this scale? And she would say one or two or three. And now they're eights or nines. They go up and down. So it's a very bland measurement tool and sometimes I feel blimey, you know, this	Client self Measurement Self-assessment

is -- but it's -- it's indicative of how successful or not that has been for her. And it also helps me when I go back to my manager and want to continue with those sessions. So it's very bland, very simple, but sometimes I will do that. And I ask my clients how do they feel about doing that? Yeah, actually I really like to see that. I really like to see that I was there and now I'm mostly over here.	Helps client motivation –take charge
663. 'Cause I --	
664. I -- oh, go.	
665. [laughter]	
666. P.6 -- so this -- I tend to with people um, it was sort of like review --	Reflection on practice with client Informed consent
667. Yeah.	
668. P.6 -- like about every -- every so many weeks or --	Regular monitoring
669. Yeah.	
670. Yeah.	
671. P.6 -- or, you know, I might feel that we've become a bit stuck or you might just want the client to reflect on where they are and what do they -- you know, what do they feel they've gained --	Consciously engaging the client in own progress
672. Yeah.	
673. P.6 -- and what do they feel they need. And I find that very helpful.	Beneficence
674. Absolutely.	
675. Yeah.	
676. P.6 And I do sometimes like use that scale of one to 10.	Numerical assessment can be effective for some
677. P.6 Not all the time.	
678. P.5 No, I don't. And I don't use it with all clients. I suppose it just --	
679. P.5 It depends.	
680. –P.5 - with some -- with some clients, I do.	
681. Yes.	
682. P.5 There are some people who like it. And you can see they like it --	
683. P.5 They like it.	
684. P.5 -- and they say they like it. And they're so	Visual changes in numerical ratings can

pleased to see the difference.	be uplifting
685. P.6 Yeah. And like -- like they'll come in -- you know, maybe when you first started seeing them, they were like -- I don't know -- a two or a three.	
686. Mmm.	
687. P.6 And they might suddenly come to a session and I'm a seven today! [laughs] Yeah!	Client self-assessment
688. P.4 I also find sometimes with suicidal -- sui-- I've had clients with suicidal ideations. Just to measure where they're at, I think that's a guide for me --	Numerical assessment less taxing on highly distressed clients
689. Mmm.	
690. P.4 -- actually to -- and I -- okay, what can we do about this? You know, do you want to lead the session? Do you want to -- or how are we going to go ahead with this? Sometimes you know, it's needed.	Joint working shared goals even for the session–engaging the client to take control in the session when they feel out of control of their lives
691. P.7 But how would you measure the success of the therapeutic alliance if you didn't have a measure?	Methods of Measuring the TA
692. ____.	
693. P.7 I think that's such a measure --	
694. [laughter]	
695. P.4 -- asking the client has really got to be the best thing. And for the client to be able to have a very simple measure like you've describe and -- and put themselves on it.	Client's perspective best Simple assessments rather than complex
696. Mmm.	
697. P.6 F: I mean I've just used that a little bit um working for a particular organization at the end of the -- the sessions just to -- you know, the client feedback.	
698. Mmhmm.	
699. P.6 And it's -- it always is very kind of interesting to -- and you know -- and affirmative to see that, you know --	
700. Yeah.	
701. P.6 -- when they first came, they felt their anxiety was a sort of nine and --	Numerical measurement effective
702. Yeah.	
703. P.6 -- their work performance was two [laughs] and now it's --	
704. Yeah. Are there --	

705. P.6 --ten or something [laughs] -- eight or whatever.	
706. P.5 But how much of that is down to the actual relationship or the therapy?	What is being measured?
707. 'P.5 Cause for me I would go with non-verbal communication probably I would use as my assessment tool on the actual relationship rather than the classics and goals --	Measure the less observable components of therapy (experiential rather than observable (tasks)
708. Mmm.	
709. –P.5 - if that makes sense. So I'd be looking at interaction, body language, tone of voice, language used, um the atmosphere within the room, the --	Experiential elements
710. Yeah.	
711. P.5 -- the atmosphere within the space between us --	Dynamics –implicit messages
712. Mmm.	
713. Yeah.	
714. P.5 --and so if body language or positioning shifted -- so you're using the kind of micro-skills and immediacy. That would all gauge up in every session.	Implicit messages as way of measuring the TA
715. Yeah.	
716. P.5 I would not be trying to read, but I would be reading the atmosphere.	Environmental signals
717. Yeah.	
718. P.5 And that would probably --	
719. Yeah.	
720. P.5 Which you do instinctively anyway.	Natural part of the process for assessing client's progress
721. P.5 Yes! It's intuitive in the sense that actually I get the sense of --	
722. Mmm.	
723. P.7-- it would be kind of then the verbal side of exploration I guess. And -- but that wouldn't be something -- and someone else observing might not measure it --	Implicit not observable, comes from within
724. P.6 Well, you can't ___ --	
725. P.6- the same way. It's very subjective.	Internal
726. P.6-- you can't measure it in a quantifiable way.	Immeasurable numerically
727. P.5 No. intuitive.	

728. P.5 ‘Cause it’s so complex, isn’t it? You’re --	
729. P.3 So you’re --	
730. P.3 -- really receiving such subtle information.	Micro-observations requiring skills
731. P.5 But I think you know.	
732. P.5 You do know. Yeah. But you can’t quantify it.	
733. ____.	
734. P.6 And the evidence-based people want the evidence.	Policy v Practicality
735. Mmm.	
736. P.3 But you know, what -- as soon as you start to quantify and give evidence in that sort of um, you know, generalized way, you’re -- you’re going away from the actual truth of the experience really, aren’t you? You’re -- you’re --	Individualism v collectivism One rule fits all
737. P.6 Yeah. The organization that I do some sessions in, we have to use an ___ session rating scale, which we have to -- one of those measures is relationship. So the client is asked to rate between one and ten, isn’t it --	Uncertainty of what is being measured
738. Mmm.	
739. P.6 -- the relationship itself. And -- which is obviously again a -- can be problematic because a client doesn’t want to disappoint you --	Pleasing the therapist
740. Mmm.	
741. P.6 -- so they’ll put a ten.	Pleasing the therapist –Inaccurate ambiguous
742. Mmm.	
743. P.6 And there’s other clients that are more necessarily honest with that kind of --	Measurement good clarification
744. Mmm.	
745. P.6 -- or have the confidence to be more honest. But I see it as that’s a measureable element of it --	Client’s measurement good indicator
746. Mmm.	
747. P.5 -- but I also see it as the actual un-measureable stuff is actually where the accurate information --	
748. Mmhmm.	
749. P.1 It’s interesting to see how we’re all talking about the client’s experience and nobody’s talking about their own experience. And I see the alliance is definitely the two, isn’t it? It’s	Two way process alliance built from both sides

two sides -- us --	
750. P.1 But that is my experience --	
751. Mmm.	
752. –P.1- ‘cause you as the therapist --	
753. Mmm.	
754. Mmm.	
755. P.1 -- feeling that intuitive sense --	
756. Yeah.	
757. P.1 -- of how it’s going.	
758. P.1 And then I would explore that with the client ‘cause I do feel very much it is a two-way process.	Therapist’s opinion of value to the client and process
759. Mmm.	
760. P.3 Absolutely.	
761. It’s not a singular --	TA measurement Collaborative
762. P.4 But I tend to think of it as what the client’s got from it. I don’t ever think about what I got for myself [laughs] because it’s -- you know, it’s quite difficult.	Emphasis differs for some therapists Client opinion most important
763. P.4 I really thought about this before I came and I -- I actually felt quite emotional thinking about it.	Introspection
764. Mmm.	
765. P.4 And I shifted something about that -- my thoughts on that. But more important, you said how do you know if it’s the process or the therapeutic alliance? To my mind, the process is the therapeutic alliance. That’s what I believe --	TA complex as different meanings for different people
766. Mmm.	
767. P.4 -- it is based on. I think that is -- it doesn’t matter what -- whether -- what your modality is, what -- that that is the key.	Therapeutic style irrelevant to building TA
768. Yes.	
769. P.7 That is -- that is -- that is what happens there. And what you’re saying about it being a two-way process, initially -- and I think it can be either/or, but for me, I think yeah, perhaps it is me, the client, and the work is the space -- the therapeutic alliance that happens between or actually perhaps we’re all different so -- but there’s me, there’s the client, and perhaps the work is the overlap in-between. So I keep grounded. I -- I am me. I have my self-awareness. I am a professional counselor. With all that said, they are them. There’s stuff that	TA Middle ground work undertaken within the relationship

they don't want to talk about from themselves. That's their identity, my identity. And the alliance is that overlap in the middle.	
770. P.4 Is it the space or is it the overlap or could it be either?	
771. P.3 It could be both. It's about where you meet in the middle.	
772. Yeah.	
773. P.4 Likely that it is --	
774. P.3 Absolutely.	
775. P.5 -- but I -- likely it is in every scenario, there's going to be a different mix of elements that are going to fundamentally feed into that relationship.	Complex –different meanings, different elements at different times
776. Mmhmm.	
777. P.5 Um and each of us as individuals, we are unique. And therefore coming into counseling, if I was a client and put myself in that perspective, I would be looking for certain things -- receptors --	Client expectations
778. Yes.	
779. P.5 -things that are triggering me that would make me feel at ease and make me feel safe.	Standing in the shoes of the client (empathic)
780. Yeah.	
781. P.5 So that individuality is going to affect that relationship.	Uniqueness of each relationship will mean different elements occur for some over other
782. Mmhmm.	
783. P.5 I remember when training, looking around the room at -- a room full of training counselors, I know within myself there was probably only seven people I would go back to. And that's not personal, but on a -- that would be the way that I would necessarily walk into that room.	Intuition –pre-therapy, on who might help
784. Mmm.	
785. P.5 And I think it's -- I -- the measureable part there I struggle with because I think it's -- I can -- I can put my measure on it as a therapist, but they're puttin' their measure on it.	Different perspectives. Client and therapist measuring something different
786. Mmm.	
787. P.5 We're looking at very different variable, very different objectives.	Measurement outcome different for client and therapist
788. P.7 Do you think then -- do you think that the client could have a different outcome to the counselor in measuring so the client could think that was a fantastic experience. That was great.	Feasibility on how the TA is measured from different perspectives

You know, I really got a lot from that. And the counselor could think oh, that was really rubbish. I was rubbish that day. Nothing worked.	Measuring different constructs
789. P.5 Completely.	Agreement
790. P.4 Do you think it could still be --	
791. P.4 I think it can be very -- I think it can be completely in con—I've -- I've gotten [laughs] when we finished -- finished with certain clients, I'd say what -- what has been helpful? What have you been able to take from it? And it's been [laughs] the ___ random thing.	Use of reflection in therapy to measure TA
792. Mmm.	
793. P.4 So I would never necessarily thought oh! When we did that exercise -- oh, right! Okay. So what was it about that exercise? And I've been telling oh, it'll be more about this. It'll be more about that.	Reflection, feedback, informed consent on process
794. Mmm.	
795. P.4 And that -- that misconception potentially --	
796. Yeah.	
797. P.4 -- but because we've got the foundation of the relationship and the openness in that relationship to explore it --	Openness and honesty builds the TA
798. Mmm.	
799. Mmhmm.	
800. P.4 --honestly, um I've been able to find that out. But I think their two perceptions are very different.	Perspectives different
801. Mmm.	
802. P.4 It's like you were saying about the kind of research paper you read about --	
803. Mmm.	
804. P.4 --the different kind of perceptions.	
805. Mmm.	
806. P.6 I think there is. And I mean, you know, I think we bring our own anxieties into things. I can remember a couple of incidents where I had somebody come, then not come. And I thought oh, God. What did I do?	Therapist performance subjectivity
807. Mmm.	
808. P.6 [laughs] Must have done something wrong. And the -- but you know -- but I've been fortunate that six months down the road, they'd come back. And actually it was nothing about	Misperceiving the situation

me at all.	
809. Yeah.	
810. P.6 So you know, we've all got our perceptions of what we think is going on in a room.	Perceptions individual for both client and therapist
811. Mmm.	
812. P.6 And actually maybe we don't [laughs] always really know.	Lack of certainty in therapy of what has assisted the process
813. P.7 Cause it's obviously always the issues with people being open about transference and counter-transference --	Client and therapist perspectives built upon their interpersonal relationship and based on relationships with others
814. Yeah. Yeah.	
815. -- and --	
816. Yeah.	
817. P.7 -- I -- and all of those kind of things.	
818. Yeah.	
819. P.6 I sometimes sit and think I only had six hours sleep last night. I wonder if that affects the sessions when I've had ten hours sleep. Does --	Mindfulness on own well-being and performance
820. P.6 The quality --	
821. Yeah.	
822. P.6 of the alliance.	
823. P.6 So -- yeah. And am I bringing --	
824. P.6 Why should there --	
825. P.6 I'm starting to think I've got to go and pick up the car 'cause it's ___ does that affect the relationship -- that alliance within the room?	External forces impacting the TA
826. P.4 -- I know what you mean about measuring and how clinical it is, and yet if as I maybe -- and lots of people believe that therapeutic alliance is the process. It is where the work happens. Then in some way, you're going to have to measure it in today's society.	TA is the work and measurement is now becoming a cultural norm
827. P.6 Completely. It's outcome-based. Everything is outcome evidence-based now.	Agreement
828. P.6 Um -- and I don't believe it can't be done. Like I say it can be done. But perhaps not in the ways we've seen in these questionnaires	Openness to the concept of measurement but simultaneously querying different methods based on current TA measures?
829. P.1 That wouldn't work for me. No.	
830. Um --	

831. Whoo.	
832. P.1 And I wonder if we'd all find our __ would become a happy medium, but it's sort of finding a way that would work. 'Cause some people must use it.	Benchmark of quality TA measurement Applicable for all
833. P.6 But the problem is that measures are only about --	
834. ___.	
835. P.6 -- they're only -- they're kind of based on a person's perception of h-- how they see it. And it may not be how someone else can see it. I mean I've had people s-- score really high, you know, on a -- you know, how you're doing. If you do like a rating scale of how you're doing, you know --	Subjective Can be inaccurate
836. Mmm.	
837. P.6 -- and they -- they put down everything's really great. And yet when they tell you about their life, there probably isn't anyone else that would think how could you [laughs] you know, that could agree that they're doing great. So it -- you know, rating scales. It's in whose eyes?	Clients sometimes score what is not being observed by the therapist Who do we believe?
838. P.1 Okay. So how else can -- how else can we measure the therapeutic alliance?	
839. P.6 Oh, I don't know, but it's – it's -- it's always going to -- it's never going to be accurate is what I suppose I'm saying. It's never going to be -- not everybody's ever going to always agree. That -- that -- it's not accurate because it depends on people's perceptions, doesn't it?	Measuring the immeasurable
840. P.1 Can you do it from a therapist's point of view or do you only do it from the client's point of view --	How do we measure Who should do the measuring
841. P.6 Maybe it's --	
842. –P.6 - anonymously. Sort of --	When and how should the measurement take place?
843. P.1 I think potentially --	
844. P.1 -- so they give it to you --	
845. –P.1 - a combination of the two might --	
846. –P.1 -and __ somewhere else.	
847. P.1 -- be the most --	
848. Yes.	
849. P.1--accurate.	
850. P.4 I think you're right.	

851. P.6 And like I said even if it's a number scale -- I hate number scales -- but even if it's a number scale --	
852. Mmm.	
853. P.6 -- you've got an overall average --	
854. Yes.	
855. -- number.	
856. P.6 And you've got an overall picture of the alliance rather than one side of it.	Numerical measuring could appear more holistic –covers the whole process rather than aspects of it
857. P.1 The thing is when you're doing it -- 'cause if you do it at the beginning, you haven't got enough relationship to base it on.	Implications for when measurement takes place Insufficient information to base measurement on
858. Mmhmm.	
859. P.1 If you do it at the end, then you're finished and you can't -- you know, so --	
860. Mmhmm.	
861. P.1 -- it's not going to help that ___ so it's just a performance measure really for the --	The end is more outcome-based than clinical based. Unable to change things at the end
862. Yeah.	
863. -- counselor.	
864. P.6 If you're asking the client to measure the counselor, if the cl-- if they know that the counselor's going to see it --	Misconception about what is being measured, therapist of TA
865. Right.	
866. P.6 -- then it's always going to affect what they're going to put on there.	Client's understanding of the TA can affect measurement
867. Yeah.	
868. P.6 If it's done at the very end of therapy when therapy's finished and it is done anonymously -- or not anonymously, but after they -- you know, not in front of the therapist. There's probably a greater chance of --	Timing may affect accuracy. Clients may feel inhibited to honestly/accurately complete measures if therapist is present
869. Mmm.	
870. P.6 --accuracy in what they put.	
871. So --	
872. P.6 But if they're actually seeing the client, there could be an -- an -- you know, I mean if I came to see you --	

873. Mmm.	
874. P.6 -- and you asked me to rate you at the end of the session --	
875. Mmhmm.	
876. P.6 - if I hadn't felt the session was very good, I might have all sorts of worries about if I honest -- answered it honestly, you know, would you still want to see me next week --	Inhibits the clients true opinions Repercussions on clients
877. Yeah.	
878. P.6 --or you know, would you -- how -- you know, would I have offended you? Would you treat me -- you know, you -- people can have ___ --	Offending the therapist who is trying to support the client
879. P.3 Is it about the -- the therapist though or is it about the working alliance? The -- the therapeutic alliance? 'Cause that's a different thing. It's about where you meet in the middle. Um and also um the therapeutic -- therapeutic alliance will change. It's got to change.	Misunderstandings on what is being measured
880. Mmm.	
881. P.6 - over a period of time. Perhaps if it could be done anonymously between the -- the -- so the two of you did it, but it wasn't something that either of you saw --	Anonymous Measurement from both client And therapist
882. That's --	
883. P.6 -- until the latter days --	
884. P.6 - it's more likely to be accurate.	
885. P.1 So measure it at the end of the first session and then measure it at the end of therapy.	Anonymous process may help with more accurate measurement, but also reflect evaluations
886. P.4 Or even beginning, middle, end. Yeah. Or whatever -- but nobody saw it --	
887. P.7 Depending how long --	
888. P.7 -- put together.	
889. P.6 I think also it's -- like I said before in the sense that I can complete it now when in three hours now --	Changeable minds
890. Yeah.	
891. P.6-- I might be in a difference place. So it's recognizing that limitation of that it's a snapshot.	Current measurement can present a limited view of the actual overall picture
892. Mmhmm.	
893. Yes.	

894. ‘P.6 Cause it is only a sn-- yeah.	
895. F: Because actually Wednesday --	Relationship differs from session to session which differs the effects of the TA
896. P.6 I feel differently.	
897. P.6 -yeah. And you might reflect on it and think actually okay, I was a little bit -- that pushed my button a little bit, but now I’ve reflected on it. I actually think that fair enough, you know.	Self reflection outside of sessions can produce different measures of the session / process
898. P.6 Or you can come back the following week and talk it all through and actually oh, yeah --	Measurement not linear
899. Mmhmm.	
900. P.6 -- it was really quite different.	
901. Yeah.	
902. ‘P.6 Cause the misconceptions ____.	
903. P.6 So there’s never going to be 100% accuracy in any --	Measuring the immeasurable
904. P.6 No.	
905. P.6 --measure.	
906. P.6 And as long as that is recognized, I guess then that’s what you can then subtract the kind of limitations --	A need to recognise complexities on human interactions and measurement of those interactions. Need to create acceptable rather than specific when not totally quantifiable. Median
907. Mmhmm.	
908. P.6 --limited data from it.	
909. P.6 Because if you have a snapshot, what if you have several snapshots? That’s the point. It does build a picture --	
910. P.6 A bigger picture.	
911. -- mmhmm.	
912. ‘P.1 Cause the only way of comparing would be to have counselling without the therapeutic relationship and counselling with it and see what the two differences are in that.	Free flowing engagement without conscious use of specific therapeutic skills Naturalistic
913. P.3 I can’t -- I can’t imagine that!	
914. P.3 How can you?	
915. P.3 How do you capture that? [laughs] No counselling skills at all. Just sit there --	
916. [laughter]	

917. P.3 --and not say anything.	
918. P.3 But there's still a relationship that you're building.	
919. Yeah.	
920. P.1 True.	
921. P.3 Not necessarily a therapeutic one.	
922. [laughter]	
923. P.3 If you talk to a complete stranger on a train --	Comparing public relationships to therapeutic relationships
924. Mmm.	
925. P.3 -- you know, you meet somebody and you instantly sort of build up a rapport with them or not as the case might be.	
926. Mmm.	
927. P.4 But you're going through this sort of empathic dance of mish-matching and mirroring and --	Interaction always take place between two people engaging whether to a greater or lesser extent on either part
928. Mmm.	
929. P.4 --non-verbal and verbal cues and things.	Implicit communication
930. P.1 So even without any counselling skills, there probably is a relationship.	Relationships exist in any shape or form,
931. P.3 Yeah.	
932. P.1 They sit in two separate rooms.	Therapeutic relationships are different
933. P.4 It is like a dance --	Dynamics involved –skills
934. P.4 A dance.	
935. P.4 --One person leads to begin with and then -- and if you get out of step, then you trip over.	Reciprocal
936. P.4 Yeah.	
937. P.4 It's very much like a dance.	
938. P.4 It is.	
939. P.4 Yeah.	
940. P.4 The relationship is like a dance.	Based on certain techniques, that can be structured or less structured
941. P.4 I was thinking that. I was thinking what type of dance do I do? I think I start off with slow waltz [laughs] very steady and sometimes somebody's jiving all around me. [laughs]	In step or out of step. Changeable
942. P.1 So really what you're saying by the sound of it, that is you can't counsel without the therapeutic relationship being working or being	

there or being whatever it is --	
943. P.1 Uh can --	
944. P.1 --a measureable entity. [laughs]	
945. P.3 Can you? I don't know. I don't know if you can or not. I ___ I could.	
946. P.4 Well, presumable when people drop out of counselling, it's because the therapeutic alliance isn't --	Presumptions on what maintains engagement
947. Mmm.	
948. P.4 -- working very well --	
949. Mmm.	
950. -- I suppose.	
951. P.2 I -- see, I wouldn't necessarily agree with that in the sense that I think there's -- there's other factors like ___ [money?].	TA not the only important entity for some clients re-engagement
952. P.2 There might be.	
953. [laughter]	
954. P.2 Being another ___.	
955. P.2 There could be a ___.	
956. P.2 It must be quite a common one for --	
957. Mmm.	
958. P.6 I think it -- also if you're going to try and um put some sort of scale on a therapeutic alliance, the client actually needs to understand what it is. And I think most clients would not actually have a clue why they're feeling better.	Clients measuring something that still remains a mystery to professionals Expectations on clients measurement of the TA may be unrealistic
959. Mmm.	
960. Mmm.	
961. P.6 They just are. And how would they quantify that?	If clients are not sure what is involved in the TA, then how can their measurement be accurate?
962. Mmhmm.	
[End of recording]	

Appendix 15: Node Listing NVivo 10

Coding Reports (3 coding reports with 79 subcategories)

Titles sorted alphabetically

Categories/Themes

1. Bordin (3 subcategories)
    - Attachment bond (8 subcategories)
        - Acceptance
        - Being liked
        - Chemistry - Dynamics - Rapport
        - Comfortable - at ease
        - Equality - Overlap
        - Feeling safe
        - Maintain approval
        - Respecting views

    - Shared goals (7 subcategories)
        - Building therapeutic alliance
        - Direction
        - Framework
        - Process and work
        - Safety
        - Structured feedback
        - Time-limited expectations

    - Tasks (13 subcategories)
        - Building therapeutic alliance
        - CBT
        - Empowerment
        - Establish credibility
        - Ethics
        - Gather information - Knowledge of client
        - Measurements
        - Non-verbal assessment
        - Openness
        - Prevent ruptures
        - Transference - Counter transference
        - Trust the process
        - Verbalise expectations

2. Factors (43 subcategories)
    - Acceptance
    - Assessment
    - Autonomy
    - Chemistry
    - Confidence
    - Credibility
    - Empowerment
    - Establish relationship

- Ethical framework
- Faith
- Feedback
- Feeling safe
- Flexibility
- Gathering information
- Genuineness - Being real
- Gets in way of therapeutic relationship
- Helpfulness
- Honesty
- Hope
- Intuition
- Limitations
- Non-verbal communication
- Not helping
- Openness
- Outcomes
- Patience
- Client-Therapist relationship
- Potential
- Pressure to speed up therapy
- Private practice
- Professional and personal self
- Projection
- Qualification
- Respect
- Self-reliance
- Spirituality
- Structure - Contracting
- Timing
- Transference - Counter-transference
- Trust
- Two-way process
- Website content
- When therapeutic alliance happens

3. Measurement (5 subcategories)
    - CBT
    - Inaccurate measures
    - Client self-assessment scale
    - Recommendations to improve
    - Use of Working Alliance Inventory & Forms

Appendix 16: Tag Cloud 1 – NVivo 10

able absolutely acceptance accepting actually alliance also always back beginning bit build building came cause client clients come confidence counseling counselor different done end even experience feel feeling felt find first get going got help hope important information just kind know laughs like little looking make may mean measure might mmhmm mmm much now obviously okay one part people person probably process put quite rather really relationship right room see sense session sessions six somebody something sometimes sort start suppose talk therapeutic therapist therapy thing things think time two use want way weeks well within work worked working yeah yes

Appendix 17: Tag Cloud 2 – NVivo 10

Appendix 18: Panel Judges Instructions

Researcher: Prior to your participation as a Panel Judge, I will provide you with a brief overview of the Therapeutic Alliance. I will then go through the procedure for data collection with you and provide you with an example on how you should approach the statements, which reflects the Thurstone equal-interval model of scaling (Thurstone & Chave, 1929).

Many researchers believe the Therapeutic Alliance to be the best predictor of therapeutic outcome regardless of the therapeutic approach. Although much has been written on the TA concept, today there is no clear definition. The TA forms part of the Therapeutic Relationship and said to be the driving force through the process of therapy (Summers & Barber, 2003). A well-documented and popular definition of the TA was developed by Bordin (1979). Bordin suggests the TA is formed through shared goals, tasks and an attachment bond. This research is intended to explore your views on the TA through experiences with your clients – past and present.

1. Please now fill in the demographic form provided?
2. You are asked to work through the statements without conferring with other judges.
3. You are asked to rate each statement 1-11 on how favourable you believe each statement fits with the concept of the therapeutic alliance. 1= least favourable-11 = most favourable. You are **not** asked to rate your personal opinion like in a Likert-type scale but to the best of your ability offer your professional opinion which reflects the Thurstone model of equal-interval scaling.

I will now offer you an example on forming a professional opinion over a personal opinion to clarify your understanding prior to the data collection.

> "If you were a Judge in a Court of Law, and the person in front of you needed to be sentenced, you would be expected to decide a sentence that best fits the seriousness of the crime and in compliance with legal proceedings. For example, hypothetically, a person who stole something expensive from a shop might result in a 2 year jail sentence. However, you might not personally agree with the sentence because of your own principles and values on the length of sentencing people for certain crimes".

Any Questions!

Thank you

Alison Walne

Researcher

Appendix 19

Please score each statement below rated 1-11.

1 = least favourable to the concept -11 == most favourable to the concept

Answers are based on '**Therapist Awareness'** of factors that attribute to a positive Therapeutic Alliance (known as 'alliance' in the statements).

Please note: you are asked to make a judgement on each statement based on your knowledge and experience of the process of therapy, and not on whether you agree or disagree like in a personal opinion.

1 Acceptance of the client and their situation is the first step in alliance-building.

1 2 3 4 5 6 7 8 9 10 11

2 Formal assessment of need in the first session is not important in alliance-building.

1 2 3 4 5 6 7 8 9 10 11

3 Gathering information as soon as possible helps build rapport with the client.

1 2 3 4 5 6 7 8 9 10 11

4 In the first session to help build rapport, it is important to help the client feel comfortable - at ease and safe.

1 2 3 4 5 6 7 8 9 10 11

5 Chemistry needs to be present in the relationship to achieve a successful outcome.

1 2 3 4 5 6 7 8 9 10 11

6 The client having confidence in the therapist's approach will help establish the alliance.

1 2 3 4 5 6 7 8 9 10 11

7 Openness and being genuine within the relationship supports the alliance.

1 2 3 4 5 6 7 8 9 10 11

8 Not judging a client gives them a sense of feeling safe.

1 2 3 4 5 6 7 8 9 10 11

9 Facing challenges within the therapeutic relationship can strengthen the alliance.

1 2 3 4 5 6 7 8 9 10 11

10 Being alongside the client rather than ahead of them in the process strengthens the alliance.

1 2 3 4 5 6 7 8 9 10 11

11 A therapist needs to bring their professional and personal self into the relationship.

1 2 3 4 5 6 7 8 9 10 11

12 Therapy is a two-way process and cannot work without mutual respect.

1 2 3 4 5 6 7 8 9 10 11

13 Gaining client trust is something that needs working on right from the start.

1 2 3 4 5 6 7 8 9 10 11

14 A focus on non-verbal communication helps the relationship and process.

1 2 3 4 5 6 7 8 9 10 11

15 Environmental factors and proximity to the client should be regularly considered.

1 2 3 4 5 6 7 8 9 10 11

16 A therapist should facilitate opportunities for the client to help themselves.

1 2 3 4 5 6 7 8 9 10 11

17 A therapist should have belief in the client's ability to make personal change.

1 2 3 4 5 6 7 8 9 10 11

18 Structuring sessions demonstrates professional credibility in driving the alliance.

1 2 3 4 5 6 7 8 9 10 11

19 The alliance starts when the first contact is made with the client.

1 2 3 4 5 6 7 8 9 10 11

20 A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.

1 2 3 4 5 6 7 8 9 10 11

21 A client's approval of the therapist is important.

1 2 3 4 5 6 7 8 9 10 11

22 A therapist needs faith in the client's self-reliance to support empowerment and change.

1 2 3 4 5 6 7 8 9 10 11

23 Regular feedback from a client shows whether the work is making a difference.

1 2 3 4 5 6 7 8 9 10 11

24 A therapist needs to be aware that a client who feels powerless, can project power onto the therapist.

1 2 3 4 5 6 7 8 9 10 11

25 Making a client feel safe in the therapeutic environment helps them open-up more.

1 2 3 4 5 6 7 8 9 10 11

26 Gaining feedback from the client throughout the process helps monitor and review the agreed goals.

1 2 3 4 5 6 7 8 9 10 11

27 A basic structure with general questions in the first session helps a client feel at ease.

1 2 3 4 5 6 7 8 9 10 11

28 Using intuition, tells you the process is working well.

1 2 3 4 5 6 7 8 9 10 11

29 Being patient with the client means work is at their pace.

1 2 3 4 5 6 7 8 9 10 11

30 The longer a therapist works with a client the better the relationship becomes.

1 2 3 4 5 6 7 8 9 10 11

31 A client should be able to be their spiritual self in therapy.

1 2 3 4 5 6 7 8 9 10 11

32 Being liked by the client helps build rapport and supports the therapeutic work.

1 2 3 4 5 6 7 8 9 10 11

33 If equality in the relationship appears uneven, dynamics should be changed verbally, or non-verbally or both.

1 2 3 4 5 6 7 8 9 10 11

34 A comfortable environment helps the client and therapist feel at ease.

1 2 3 4 5 6 7 8 9 10 11

35 Offering reassurance on confidentiality and boundaries helps a client feel safe.

1 2 3 4 5 6 7 8 9 10 11

36 A therapist should be aware that time-limited therapy speeds up the process, but could reduce the quality of the alliance.

1 2 3 4 5 6 7 8 9 10 11

37 A client needs direction in therapy to help the process.

1 2 3 4 5 6 7 8 9 10 11

38 In a brief therapy service, client expectations should be explored, and provision explained right from the start.

1 2 3 4 5 6 7 8 9 10 11

39 A CBT approach means a therapist can plan ahead to achieve agreed goals.

1 2 3 4 5 6 7 8 9 10 11

40 Knowing what is involved in alliance-building rather than numerical measurement, is what makes

the process work.

1 2 3 4 5 6 7 8 9 10 11

41 A therapist needs to put trust in the process for it to work.

1 2 3 4 5 6 7 8 9 10 11

42 Random numerical measurement of the alliance, by the client, e.g. 1-10, provides valuable information on their progress.

1 2 3 4 5 6 7 8 9 10 11

43 The process of therapy can move at different paces and in different directions. Thus sessional measurement may not reflect the overall measurement on outcome.

1 2 3 4 5 6 7 8 9 10 11

44 The alliance can be affected according to a client's readiness to engage.

1 2 3 4 5 6 7 8 9 10 11

45 A client does not have to like the therapist as long as they like the work being done.

1 2 3 4 5 6 7 8 9 10 11

46 A therapist should be aware that numerical measurement of the alliance has advantages, but may not reflect accuracy, according to how, when, and by whom this is obtained.

1 2 3 4 5 6 7 8 9 10 11

47 A client self-assessment scale could be effective for reflecting own progress.

1 2 3 4 5 6 7 8 9 10 11

48 To improve accuracy, a client needs to understand what is being measured in therapy.

1 2 3 4 5 6 7 8 9 10 11

49 The use of reliably-tested alliance measurement themes could be helpful in sessions.

1 2 3 4 5 6 7 8 9 10 11

50 A therapist needs to be mindful of their own well-being on performance in therapy.

1 2 3 4 5 6 7 8 9 10 11

51 A client might value a brief therapeutic intervention as long as they know this from the outset.

1 2 3 4 5 6 7 8 9 10 11

Appendix 20: Panel Judges Initial Statements Scores

P's	1	2	3	4	5	6	7	8	9	10	11
S1	8	9	10	11	8	10	10	11	9	4	11
S2	6	7	8	11	6	2	3	9	7	6	5
S3	9	3	1	1	8	11	4	10	5	6	6
S4	11	11	11	11	10	10	9	11	11	8	9
S5	8	1	7	5	4	3	3	4	4	2	8
S6	10	11	10	11	2	9	8	4	10	10	10
S7	11	11	11	11	11	10	10	11	9	9	10
S8	9	11	11	11	11	8	8	11	9	10	10
S9	8	11	9	11	8	10	6	10	9	11	10
S10	7	9	11	11	10	6	3	10	9	10	9
S11	9	6	8	11	10	7	9	7	8	9	8
S12	8	11	10	11	8	7	7	11	7	7	8
S13	11	10	10	8	10	10	4	4	10	10	8
S14	4	10	9	7	8	6	9	7	8	10	10
S15	5	7	11	8	8	6	2	9	9	10	9
S16	8	6	11	11	9	10	6	9	8	10	10
S17	8	6	11	11	8	11	8	11	7	11	11
S18	4	7	10	1	3	9	2	4	5	1	7
S19	9	11	11	11	9	11	7	11	9	11	10
S20	8	11	10	6	7	9	9	10	10	11	9
S21	8	8	8	8	6	8	4	4	8	1	9
S22	9	6	10	2	7	1	3	10	7	11	11
S23	11	9	9	6	4	10	6	8	8	5	8
S24	7	8	9	11	8	1	4	9	9	11	8
S25	9	11	11	11	11	10	9	7	10	11	9
S26	10	11	11	11	8	11	8	9	10	10	5
S27	8	7	10	6	9	6	6	4	9	8	6
S28	6	2	9	7	9	4	8	4	6	3	6
S29	8	9	11	11	11	6	6	9	6	3	5
S30	3	1	9	6	3	2	8	5	6	1	3
S31	6	4	5	11	10	6	10	11	9	4	8
S32	7	7	6	9	9	7	7	7	8	2	8
S33	8	9	9	11	6	3	4	9	9	1	6
S34	8	6	11	11	7	8	6	9	10	8	9
S35	10	9	11	11	10	8	9	10	10	8	11
S36	5	7	8	11	3	2	3	10	7	4	8
S37	6	9	6	1	5	11	4	7	9	4	9
S38	8	11	11	11	9	11	5	10	9	9	9
S39	7	11	11	11	3	8	5	4	6	6	8
S40	9	8	10	6	11	6	9	11	9	9	8
S41	7	9	10	11	7	9	6	11	10	8	8
S42	8	8	11	11	3	1	3	1	7	5	10
S43	7	11	10	11	11	6	9	10	10	9	8
S44	8	6	11	11	11	8	9	10	10	9	10

S45	7	6	7	11	5	8	9	3	4	7	10
S46	6	11	10	11	9	8	6	10	8	6	9
S47	8	8	10	11	9	8	3	9	8	8	8
S48	8	6	11	11	6	10	3	9	10	8	6
S49	9	8	11	11	7	8	3	2	9	10	6
S50	8	8	11	11	8	10	9	10	9	10	9
S51	7	11	8	11	8	11	9	10	9	10	9

Appendix 21: Panel Judges Statement Analysis: 51 Statements

Statement Number	Median	Q1	Q3	Interquartile Range	Semi- IQ
1	10	8	11	3	1.5
2	6	5	8	3	1.5
3	6	3	9	6	3
4	11	9	11	2	1
5	4	3	7	4	2
6	10	8	10	2	1
7	11	10	11	1	0.5
8	10	9	11	2	1
9	10	8	11	3	1.5
10	9	7	10	3	1.5
11	8	7	9	2	1
12	8	7	11	4	2
13	10	8	10	2	1
14	8	7	10	3	1.5
15	8	6	9	3	1.5
16	9	8	10	2	1
17	11	8	11	3	1.5
18	4	2	7	5	2.5
19	11	9	11	2	1
20	9	8	10	2	1
21	8	4	8	4	2
22	7	3	10	7	3.5
23	8	6	9	3	1.5
24	8	7	9	2	1
25	10	9	11	2	1
26	10	8	11	3	1.5
27	7	6	9	3	1.5
28	6	4	8	4	2
29	8	6	11	5	2.5
30	3	2	6	4	2
31	8	5	10	5	2.5
32	7	7	8	1	0.5
33	8	4	9	5	2.5
34	8	7	10	3	1.5
35	10	9	11	2	1
36	7	3	8	5	2.5
37	6	4	9	5	2.5
38	9	9	11	2	1
39	7	5	11	6	3
40	9	8	10	2	1
41	9	7	10	3	1.5
42	7	3	10	7	3.5
43	10	8	11	3	1.5
44	10	8	11	3	1.5
45	7	5	9	4	2
46	9	6	10	4	2
47	8	8	9	1	0.5
48	8	6	10	4	2
49	8	6	10	4	2
50	9	8	10	2	1
51	9	8	11	3	1.5

Appendix 22: Online Survey Front Page

Therapeutic Alliance

Dear Participant,

Qualified Counsellors / Psychotherapists / Psychologists / Clinical Supervisors /Nurse Therapists and Trainee Therapists Required.

This survey is part of an exciting research study (Ethical approval number: Reference: 'PSYETH 11/12 005') being undertaken to identify what specific factors are involved in the therapeutic alliance (TA), as uncertainty still remains. The TA is currently conceptualised as 3 components: attachment bond, tasks, and shared goals (Bordin, 1979), and known to be the best predictor of therapeutic outcome, independent of the therapist's approach. Therefore, in times where demand for evidence-based - quality therapy is on the increase, we need to get it right.

Your participation will help to clarify if TA factors identified in this research, are viewed as favourable to the concept of the TA, or not as the case may be.

A new TA process measure is being constructed based on these factors and your responses, to help heighten awareness for trainees, therapists and supervisors, on therapeutic process.

Please note: By completing this survey you are voluntarily consenting to participate in this research and your anonymity will be protected at all times in line with BACP and BPS ethical guidelines on research.

Your scores on responses will be displayed to the author only, as part of the data collection, but you can opt to obtain a confidential response by entering your e mail address at the end of the survey.

The author is a Health Care Professions Council (HCPC) Registered, Practioner Psychologist and BPS Chartered Psychologist, a Full Member of BACP, and Psychology Doctorate Student at City University, London.

Thank you

Alison Walne

Researcher

Appendix 23: The Online Survey Scale Items: Web-Site Participants

1	The therapeutic alliance starts when the first contact is made with the client. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
2	Gaining client trust is something that needs working on right from the start. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
3	In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
4	A basic structure with general questions in the first session helps a client feel at ease. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
5	Formal assessment of need in the first session is not important in alliance-building. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
6	Not judging a client gives them a sense of feeling safe. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
7	Offering reassurance on confidentiality and boundaries helps a client feel safe. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
8	Openness and being genuine within the relationship supports the therapeutic alliance. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
9	A focus on non-verbal communication helps the relationship and process. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
10	Structuring sessions demonstrates professional credibility in driving the therapeutic alliance. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
11	A flexible approach to therapeutic work is crucial for a client who finds engagement difficult. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
12	A client who feels powerless, can project power onto the therapist. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
13	Being liked by the client helps build rapport and supports the therapeutic work. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
14	Intuition tells you the process is working well. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
15	A client needs direction in therapy to help the process. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
16	In a brief therapy service, client expectations should be explored, and service provision explained right from the start. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
17	A therapist needs to bring their professional and personal self into the relationship. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
18	Chemistry needs to be present in the relationship to achieve a successful outcome. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
19	The longer a therapist works with a client the better the relationship becomes. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
20	A client self-assessment scale could be effective when reflecting own progress. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
21	A client does not have to like the therapist as long as they like the work being done. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
22	A therapist needs to be mindful of their own well-being on performance when offering therapy. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree

	The following statements 23-26 were added to the web-site research survey, in relation to the 2nd research question. Could a new Ta measure heighten awareness on therapeutic process? Statement 27, allowed for views who did not favour a TA measure.
23	In training, a reflective TA process measure on factors identified could heighten trainee awareness on therapeutic process. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
24	In practice, a reflective TA process measure on factors identified could heighten therapist and trainee awareness on therapeutic process Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
25	In clinical supervision, a reflective TA process measure on factors identified could heighten supervisor and supervisee awareness on therapeutic process and skills. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
26	In my practice, a reflective TA focus measure on factors identified could help evidence how successful outcomes are achieved. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
27	A TA measure is not necessary in therapeutic practice. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree

Appendix 24: Rotated 2 Factor Matrix

	Factor	
	1	2
1. The therapeutic alliance starts when the first contact is made with the client.	-.096	-.110
2. Gaining client trust is something that needs working on right from the start.	.589	.143
3. In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe.	.482	.333
4. A basic structure with general questions in the first session helps a client feel at ease.	.022	.548
5. Formal assessment of need in the first session is not important in alliance-building.	.221	-.052
6. Not judging a client gives them a sense of feeling safe.	.598	.143
7. Offering reassurance on confidentiality and boundaries helps a client feel safe.	.649	.091
8. Openness and being genuine on both parts within the relationship supports the therapeutic alliance.	.417	.275
9. A focus on non-verbal communication helps the relationship and process.	.333	.100
10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.	.118	.613
11. A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.	.477	-.009
12. A client who feels powerless, can project power onto the therapist.	.324	-.087
13. Being liked by the client helps build rapport and supports the therapeutic work.	.094	.641
14. Intuition tells you the process is working well.	.313	.022
15. A client needs direction in therapy to help the process.	.050	.573
16. In a brief therapy service, client expectations should be explored, and service provision explained right from the start.	.563	-.002
17. A therapist needs to bring their professional and personal self into the relationship	.347	.193
18. Chemistry needs to be present in the relationship to achieve a successful outcome.	.032	.244
19. The longer a therapist works with a client the better the relationship becomes.	.018	.163
20. A client self-assessment scale could be effective when reflecting own progress.	.177	.540
21. A client does not have to like the therapist as long as they like the work being done.	.062	-.314
22. A therapist needs to be mindful of their own well-being on performance when offering therapy.	-.572	.202
Extraction Method: Principal Axis Factoring. Rotation Method: Varimax with Kaiser Normalization.		
a. Rotation converged in 3 iterations.		

Communalities		
	Initial	Extraction
1. The therapeutic alliance starts when the first contact is made with the client.	.215	.021
2. Gaining client trust is something that needs working on right from the start.	.430	.368
3. In the first session to help build rapport with the client, it is important to help them feel comfortable - at ease and safe.	.419	.344

4. A basic structure with general questions in the first session helps a client feel at ease.	.399	.300
5. Formal assessment of need in the first session is not important in alliance-building.	.279	.051
6. Not judging a client gives them a sense of feeling safe.	.532	.378
7. Offering reassurance on confidentiality and boundaries helps a client feel safe.	.520	.429
8. Openness and being genuine on both parts within the relationship supports the therapeutic alliance.	.401	.249
9. A focus on non-verbal communication helps the relationship and process.	.281	.121
10. Structuring sessions demonstrates professional credibility in driving the therapeutic alliance.	.439	.390
11. A flexible approach to therapeutic work is crucial for a client who finds engagement difficult.	.382	.227
12. A client who feels powerless, can project power onto the therapist.	.291	.113
13. Being liked by the client helps build rapport and supports the therapeutic work.	.455	.420
14. Intuition tells you the process is working well.	.384	.098
15. A client needs direction in therapy to help the process.	.487	.331
16. In a brief therapy service, client expectations should be explored, and service provision explained right from the start.	.421	.317
17. A therapist needs to bring their professional and personal self into the relationship	.403	.158
18. Chemistry needs to be present in the relationship to achieve a successful outcome.	.357	.060
19. The longer a therapist works with a client the better the relationship becomes.	.265	.027
20. A client self-assessment scale could be effective when reflecting own progress.	.442	.323
21. A client does not have to like the therapist as long as they like the work being done.	.383	.103
22. A therapist needs to be mindful of their own well-being on performance when offering therapy.	.433	.368
Extraction Method: Principal Axis Factoring.		

Appendix 25: Demographic Open Question 1

Demographic question If applicable, please state in the box below which Therapeutic Alliance measure/s you currently use? State NA if don't use any, or state another form of how you measure the Therapeutic Alliance.

	Frequency	Percent	Valid Percent	Cumulative Percent
	26	28.6	28.6	28.6
another form	1	1.1	1.1	29.7
Ask the client how therapy is for them	1	1.1	1.1	30.8
BAAT PROFORMAS	1	1.1	1.1	31.9
CORE	1	1.1	1.1	33.0
Core 34	1	1.1	1.1	34.1
CORE in some cases and Client feedback	1	1.1	1.1	35.2
Here and now with client.	1	1.1	1.1	36.3
I am not sure what a Therapeutic Alliance measure is..so I have no idea if I use it or not! I use CORE sheets and NVC and intuition and supervision to judge my relationship with a client. Sorry...it's not something we have specifically studied..or not under this 'name'.	1	1.1	1.1	37.4
I ask questions reflective of the issues pertaining to the original assessment	1	1.1	1.1	38.5
I do regular reviews with clients	1	1.1	1.1	39.6
I use my own framework, nothing formal	1	1.1	1.1	40.7
Interview	1	1.1	1.1	41.8
Measure the alliance through therapeutic reviews and addressing it in sessions	1	1.1	1.1	42.9
NA	45	49.5	49.5	92.3
Own measure?	1	1.1	1.1	93.4
Reflective	1	1.1	1.1	94.5
review discussion with client every 5 - 6 weeks .	1	1.1	1.1	95.6
Self and Relational reflexivity	1	1.1	1.1	96.7
Through the clients response to the work and confidential questionnaires given to clients by agency at end of work	1	1.1	1.1	97.8
Typically used a 'low level' Client Satisfaction Q (inc. questions relating to the therapeutic relationship)	1	1.1	1.1	98.9
Work Experience Alliance Form	1	1.1	1.1	100.0
Total	91	100.0	100.0	

Appendix 26: Demographic Open Question 2

Demographic question: One-way frequency table of previous role

	Frequency	Percent	Valid Percent	Cumulative Percent
	5	5.5	5.5	5.5
Admin	1	1.1	1.1	6.6
Asst. Psych	1	1.1	1.1	7.7
Asst.Psych.	1	1.1	1.1	8.8
Care W	1	1.1	1.1	9.9
Care W.	3	3.3	3.3	13.2
counsellor	1	1.1	1.1	14.3
CPN	1	1.1	1.1	15.4
Ed.	1	1.1	1.1	16.5
ED.	1	1.1	1.1	17.6
Ed. Psych	1	1.1	1.1	18.7
Health	1	1.1	1.1	19.8
None	1	1.1	1.1	20.9
Nurse	7	7.7	7.7	28.6
OT	1	1.1	1.1	29.7
Other	45	49.5	49.5	79.1
Psychol.	1	1.1	1.1	80.2
Psychotherapist	1	1.1	1.1	81.3
Social Care	1	1.1	1.1	82.4
Social W.	2	2.2	2.2	84.6
Suppt. W	2	2.2	2.2	86.8
Systemic Family therapist	1	1.1	1.1	87.9
Teacher	1	1.1	1.1	89.0
Teacher	7	7.7	7.7	96.7
Therapeutic Creative Practitioner	1	1.1	1.1	97.8
Therapist	1	1.1	1.1	98.9
Yes. Pastoral care worker, school	1	1.1	1.1	100.0
Total	91	100.0	100.0	

Part D: Critical Literature Review

Clinical Supervision Competences: An International and National Perspective

6.1 Rationale

The decision to undertake a critical literature review on clinical supervision competences was influenced by increasing calls for accountability and evidence-based practice in psychological therapies, including, therapeutic alliance factors and their relationship to how evidence could be obtained qualitatively in therapy (discussed within a three-factor model, in section B and in practice, in section C of this portfolio), to help develop clinical competences, which aim to ground our interventions within the latest research findings (Lane & Corrie, 2006; Milne, 2009). As we move forward in this direction, more rigorous standards for accountability and transparency on practice are likely to be imposed on methods and means of obtaining evidence. Clinical supervision was part of the drive to modernise the National Health Service (NHS), governed by the Department of Health in 1998 (Milne, 2010). Citing Green (2004), continuous professional development (CPD) in the NHS for supervisors has been largely overlooked (Milne, 2010).

Counselling psychology has been fundamental in developing clinical supervision in the United Kingdom (UK) (Woolfe & Tholstrup, 2010). As we now have more international links with other countries through the Internet, webinars, and international travel, this allows for a broader examination of the challenges brought by supervision competences.

In this review, particular attention is given to literature on competence-based supervision from over the last decade because it was from around 2004 that US counselling psychologists participated in defining and articulating basic competences relating to professional practice (Falender & Shafranske, 2004; 2007). Within this era, US counselling psychologists were central to the development of standardising specific competences for education and training, and subsequently for professional psychologists (Forrest, 2010). To orientate the reader, following the introduction an outline of key principles and values of counselling psychology are presented. These

principles and values are enveloped within the review. Historical factors on clinical supervision set the scene for the main review.

6.2 Introduction

Evidence has revealed that supervision competences could apply to all psychologists, counsellors, and psychotherapists (Owen-Pugh & Symons, 2013). Interestingly, the topic was discussed earlier from mainly a counselling psychology and US perspective. However, in the UK, more recently there seems to be more emphasis on the subject from a clinical psychology perspective (Milne, 2009; Milne; 2010, Reiser & Milne, 2012; Roth and Pilling, 2007; 2008; 2009; Roth, Hill & Pilling, 2009).

As well as the developments through the British Psychological Society (BPS), there has also been increasing interest in supervision competences from our colleagues across the globe. Contributions have been made from Australia, Canada, New Zealand (Falender, 2014), and South Korea (Forrest, 2010). Falender (2014) reports that both the US and Canada have played a major role in the development of counselling psychology supervision competences. In 2010, there was a call for internationalisation on standardising competences (Forrest, 2010).

Work on clinical competences has been underway within the United Kingdom (UK) since the late 1990s as part of the NHS 'agenda for change' and 'knowledge and skills framework' (Owen-Pugh & Symons, 2013). These new policies were introduced to develop the skills of current employees. This led to the introduction of the NHS 'Improving Access to Psychological Therapies' (IAPT) service to provide easier access to services for people with anxiety and depression. A competences framework was constructed to support and assess practice (Roth & Pilling, 2007, 2008, 2009).

In the UK, supervision competences were initially considered for cognitive behavioural therapy (CBT) and IAPT services, introduced through Roth and Pilling's (2009) 'Competence Framework for the Supervision of Psychological Therapies' (Owen-Pugh & Symons, 2013). In a quest to produce a workable competency framework for CBT, decisions needed to be made between competences that were defined too simply or too exhaustively. The former would mean that most would meet the standards and with the latter few people would meet the criteria. A framework was constructed that provided

enough detail in a format that provided good utility to aid practice and 'best practices', due to its components (Roth & Pilling, 2008). Later Roth, Hill, and Pilling (2009) introduced a humanistic framework. Subsequent to this, psychoanalytical and systems theory competency frameworks were developed based on similar principles in earlier frameworks constructed by Roth and Pilling.

The aim of this review is to discuss supervision competences from the current literature and to reflect the UK position. The main question proposed is:

"What are the main challenges attributed to supervision competences?"

To answer this important question, the review considers supervision competences as reflecting six key areas considered relevant to the professional standpoint for psychological therapists in all countries. The factors include:

1. Benefits of international integration on competence.
2. Supervision competences and implications for training.
3. Supervision competences and implications for professional psychologists as supervisors.
4. Cultural shifts in the supervisory relationship.
5. Cultural awareness within the supervision process.
6. Ethical issues associated with safe and effective supervision practice.

It is proposed that an examination of these six commonalities will help raise awareness in practice on supervision competences for all, rather than delineate differences that can occur across cultures. Conclusions are drawn, which consider important matters in supervision practice that befit all psychologists throughout the world.

6.3 Counselling Psychology

The Division of Counselling Psychology is part of the British Psychological Society (BPS), which abides by the BPS Code of Ethics and Conduct (2009). Some of counselling psychology priorities and therapeutic focus are defined as:

- An increasing awareness among many psychologists of the significance of the helping relationship;
- A growing questioning of the 'medical model' of professional-client relationship and a move towards a more humanistic value-base;

- A developing interest in facilitating well-being as opposed to responding to sickness and pathology (Strawbridge & Wolfe, 2010, p.4).

6.4 The Development of Clinical Supervision

Derived from the psychoanalytical era, a man called Max Eitington is said to have made supervision a formal requirement in the 1920s. By the 1950s, as the role of supervision developed, it primarily appeared to reflect the principles of counselling; the supervisee (trainee therapist/therapist) was understood to have played out the relationship with their client in his or her relationship with the supervisor. Today this type of practice is known as the 'parallel process' because the relationship with the client/therapist can parallel that of the supervisee/supervisor (Woolfe & Tholstrup, 2010).

"The emphasis from within counselling psychology on the 'reflective-practitioner' model as the best way to define a counselling psychologist gave supervision its credibility. Supervision was the reflection on the practice aspect of the clinical work" (Caroll, 2007, p. 34)

Supervision research and literature was adopted in the US and developed particularly within counselling psychology. From the 1970s, supervision took on a more educational position. This meant the role of supervision shifted away from the person doing the work, to the work itself, and by the 1980's models of supervision transferred from the US, and became embedded within the British culture of counselling and counselling psychology and psychotherapy, and became a requirement by the British Association of Counselling and Psychotherapy (BACP) and integral to training (Carroll, 2007). The UK Division of counselling psychology was the first in the British Psychological Society (BPS) to insist on supervision for all members regardless of their level of qualification or seniority. Supervision for 'all', has since been acknowledged across the society (Woolfe & Tholstrup, 2010).

In this review supervision remains focused on the one-to-one therapeutic process, which is an adjunct to professional practice in the context of the therapeutic relationship between client and therapist and therapeutic outcome.

6.5 The Role of the Supervisor

Summarised from the 'Care Quality Commission', a supervisor should:

- Adopt a supportive and facilitative approach to help supervisees;
- Ensure supervisees are aware of roles, responsibilities, and boundaries;
- Keep a record of supervision sessions;
- Act appropriately and share information;
- Keep up to date with their own professional development including ensuring that they have access to their own supervision (Care Quality Commission, 2013).

6.6 The Role of the Supervisee

Summarised from the 'Care Quality Commission', a supervisee should:

- Prepare for supervision sessions;
- Take responsibility for making effective use of time;
- Take an active role in their personal and professional development (Care Quality Commission, 2013).

It is important to acknowledge that supervisors have responsibility for supervisees' learning and professional identities in relation to clients. However, the responsibility of supervisors is not just to measure the work, but to offer a safe environment where the supervisee might express doubts about "their abilities to function in their work through absorbing the disturbance from clients" (Hawkins & Shohet, 2007). This does not mean supervision is therapy, nor is it the role of the supervisor to solve the supervisee's personal problems (Prasko, Vyskocilova, Slepecky, & Novotny, 2011). In essence, the supervisory relationship focuses on the 'being-in-relation', which focuses on both the supervisor and supervisee relationship. "This in-between emphasis, which translates into a mutual, phenomenological, and relational stance can create conditions for a truly collaborative learning endeavour" (Hitchings, 2008).

6.7 Defining Competences

Within the supervision competences literature, US authors propose there is growing interest on a prescriptive standpoint on supervision that can be recognised cross-culturally (Falender, Burnes, & Ellis, 2013). A model of supervision competences based on what Watkins (2012) describes as a 'one for all' model has been suggested. On the other hand, what is also acknowledged is that supervisees will be at different

professional levels of needs. Moreover, supervision models reflect development that is not linear, for example, as in the development of the discrimination model (Bernard, 1979) and the integrative developmental model (Stoltenberg, McNeill, & Delworth, 1998).

Falender and Shafranske (2007) offer the following definition on supervision competences:

> Defining supervision competencies may be complex because competencies are not static, but a continuous part of professional development. *Competency-based supervision* is defined as an approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion referenced competence standards in keeping with evidence-based practises and requirements of the local clinical setting" (Falender & Shafranske, 2007, p.233).

6.8 International Integration on Competences

Although in the 1980s and 1990s there was a lot of attention given to supervision and the models of supervision that support the needs of the supervisee and the process (Stoltenberg, 1997; Holloway, 1995), initial developments towards a competency-based practice framework first occurred in the US in 1996 with the revision of *Guidelines and Principles for Accreditation of Programs in Professional Psychology* by the American Psychological Association (APA) in 1996 (Forrest, 2010). At this point the focus was on outcomes where broad general competences were introduced. It was not until 2001 that more specific competences were defined (Forrest, 2010). In the US, over the last decade in particular, there has been an increasing call for accountability and evidence-based psychotherapeutic practice; this is also happening in the UK (Lane & Corrie, 2006; Milne, 2009).

Internationalisation and Competency Movement

At the time of writing her position on 'Internationalisation' and competences, counselling psychologist, Linda Forrest, was president of counselling psychology in the US. During her address to the 2008 International Counseling Psychology Conference, Forrest sends a strong message on three key ideas:

1. The need for internationalisation on psychology so that we become learning partners;
2. Uniting this movement with identification and codifying of standards on competencies to promote greater consistency within psychology as a whole;
3. The disposition of 21st century leaders, seen as 'the glue' that will help create the connection between the first two movements (Forrest, 2010).

Forrest pays greater attention to the first two ideas and sums up with the latter. Forrest proposes several advantages of 'internalisation' which includes developing and learning from other countries, as well as the need to share information and learn from various cultures. Forrest openly draws attention to the narrowness of knowledge of the US position on counselling psychology. This seems to have resulted from remaining somewhat detached from other cultures.

Forrest subsequently acknowledges the need for an internal review of US practices, not only because of the recognition of multicultural issues inside the US, but because other countries have historically looked to APA for ethical guidance, accreditation, and licensing laws (Forrest, 2010). Forrest goes on to report the US's pending isolation from other countries that have become more connected in psychology (Forrest, 2010).

A final point of reference on Forrest's position draws attention to the cultural shift in competences in psychology. Here, Forrest refers to a move away from competences that will have been completed as part of the specifics of a training course, towards a more direct assessment of demonstrated competences in practice within the workplace. This is parallel with the UK position. Forrest suggests: "The change to a focus on competence in this direction has happened for a myriad of reasons: (a) a growing expectation that educational programs will produce competent graduates, (b) an increasing commitment to license only individuals who are competent, and (c) public policy makers' and consumers' increasing demand for competent professionals" (Forrest, 2010, p.100). Each of these positions are said to help trainers and trainees review their competences and assessments on competences. Forrest recommends that the US drives the international movement on psychology competences for the reasons stated and embraces opportunities for greater integration to broaden the US perspective. In 2013, there have been advancements on internationalisation from the Association of State and Provincial Psychology Boards (ASPPB) "the Norwegian Psychological Association,

and the APA to develop international competencies for entry to practice or point of licensure for Psychologists" (Falender, 2014, p.10).

The key point of interest from this paper is its recent publication in 2010. Reasons for driving the international movement forward seem professional and political. While Forrest's perspective and openness on the US counselling psychology's position highlights vulnerability if they remain isolated on practice, Forrest acknowledges US strengths on leadership and professional licensing. Forrest claims a solitary standpoint does not allow for the broader cultural aspects of human psychology experienced throughout the world and in different cultures within US society. This may be true of all countries and suggests internationalisation would be a shared entity where each country could gain from one another. Forrest recommends a focus on competences 'post-training' in the workplace rather than 'in training', principles that reflect and have been adopted in the UK. The next paper however, suggests the focus on competences needs to be in the learning environment, highlighting advantages on earlier competences development.

6.9 Supervision Competences: Implications for Training

Grus (2013) describes competences as representing a minimum threshold and that supervision is a competency. In education and training Grus (2013) posits two basic aspects: 'input' which is the instructors' qualifications and approach supports learning, and 'output' which is what the trainee is supposed to be able to 'do' based upon their learning experience.

In the context of counselling psychology Grus (2013) reports that training begins with the acquisition of theories about the makeup of the individual, their development, personality, and environment. Early training also includes the teaching of ethics, diversity, research design, measurement, and statistics collectively to support the formation of the counselling psychologist. Functional competences (case conceptualisation and psychological assessment testing) are built upon foundational knowledge and basic helping skills, such as role-play and working through case vignettes, and practice with voluntary clients leading to work with real clients (Fuertes, Spokane, & Holloway, 2013).

Grus discusses the development of benchmark policies in supervision, emphasising that 'essential components' of competences are embedded within domains, such as reflective practice, self-assessment, and self-care. However, at this point, to enlighten the reader, it would have been more helpful for the author to have offered one or two specific examples, which could have supported understanding on these points.

Grus (2013) has suggested that if we consider competency models and their focus on student learning outcomes, this will help us better understand the similarities and differences in education across countries. Agreed upon standards on performance would allow for a common vocabulary on expectations.

Grus proposes that having a 'benchmark' model system, one that standardises the different elements of competency practices, would help address competences individually and could ease the complexity of the model. Coupled with this, Grus suggests supervisors need relationship competency and cultural diversity competency. For example, it is suggested emotional responsiveness and caring to promote professional competency could be addressed through the concept of 'communitarianism', meaning, a competent community which values and promotes quality in the education and training of professional psychologists. Grus develops this idea by recognising the need to bring supervision into the education and training arena. Grus also notes that many psychologists offer supervision without supervisory training.

The paper by Grus led to further questions, such as what types of training models might best support the novice and the experienced supervisor because of lack of empirical knowledge on the process and because Grus claims supervision is still one of the least understood competences.

Key points of this paper are that (as a recent publication) Grus offers reference to the importance of education and training on supervision and that it could support supervisor competencies. This implies earlier training on the supervision processes as part of professional development could aid transition from supervisee to supervisor. For example, clinical competence does not automatically mean supervisory competence (Falender, 2014). From the UK perspective, Hitchings (2008) raises the important point that currently there is little training on 'how to be a supervisee'. In this case, if

supervisees do not know how to be supervisees, how can supervisors without training know how to be supervisors? A lack of supervisor training is also reflected on by Falender (2014).

More emphasis seems to be placed on technical expertise in supervision rather than on 'being-in-relation'. This may be because 'being-in-relation' is more difficult to teach and to measure (Hitchings, 2008). Yet, supervision literature centralises the 'being-in-relation' and the in-between stance in supervision, which reflects the phenomenological and relational aspects of supervision that are collaborative in nature (Hitchings, 2008). The concept of 'communitarianism' recommended by Grus (2013) seems based upon the values of humanistic philosophy requiring an open, emotional, responsive, and caring role model to enhance learning. Thus from the humanistic value-base of professional, unconditional, positive regard, this standpoint bodes well within UK counselling psychology training and practice (Milton, 2008).

6.10 Supervision Competences: Implications for Professional Psychologists as Supervisors

Developing on their earlier work on clinical supervision in 2004, Falender and Shafranske (2007) have since discussed perspectives on competency-based supervision, which focused upon contextual and practice issues. This position forms the criteria towards establishing the threshold on standards in practice and to encourage professional development of psychologists.

Falender and Shafranske (2007) present a convincing account on the advantages of a supervision competency framework (SCF), which reflects the many principles and values of counselling psychology that involve self-awareness (Hitchings, 2008). The driving force behind a SCF is the American Psychological Association (APA) with its premise based upon medical principles of safe practice and public policy in protecting clients through continued professional development (Forrest, 2010). Falender and Shafranske (2007) offer six core challenges that they believe psychologists face as supervisors including the subsequent effects on supervisees' learning, skills, and knowledge on the achievement of competences. These are summarised here. A detailed account can viewed in the article on pages 236 and 237.

- Preparation to conduct clinical supervision;

- Self assessment;
- Ethical competence;
- Incompetence, measured through metacompetences;
- Diversity and multicultural competence;
- Professional development.

The difficulty envisioned by Falender and Shrafanske (2007) in putting a competency-based framework together is identifying what the essential components are as opposed to how they can be assessed. For example, Milne (2009) in the UK reports that competency frameworks can be prescriptive and therefore do not address what actually happens in supervision.

An important standpoint in counselling psychology is the ability to be creative (see Carroll, 2008). Falender and Shrafanske claim that if competences are to become serial in nature this suggests the creativity in the profession of psychology could be taken away. If we strive for generalisability, the lack of creativity can itself be paradoxical. To avoid this, the authors suggest the supervisor needs orientation as part of the development process of supervisees. They infer that this might show less fluidity on the diversity of each competency, taking into account culture, context, and value. They propose another way to manage the process of supervision competences is through the concept of 'Metacompetences'. This concept was described as 'knowing about what one knows and does not know'. From the UK perspective, Milton (2008) posits that metacompetences are about thinking critically, which is an important function in the supervision process and in counselling psychology practice.

Clinically speaking, metacompetences refers to:

- The use of available skills and knowledge, to solve problems or tasks;
- The determination of which skills and/or knowledge are missing, and methods to acquire these, as well as whether they are essential to success.

Therefore, a prerequisite to 'metacompetences' is the ability to introspect (think inwardly) about one's personal cognitive processes, and it is dependent on self-awareness, self-reflection, and self-assessment (Falender & Shrafanske, 2007).

Concluding their argument for SCF, the authors claim that if one is able to identify specific competencies at the molecular level, this will allow for easier measurement because the smallest units of competences allows for self-assessment and feedback on performance. They also claim that if we can identify the smallest component within the competency as a whole, this will support areas of improvement more specifically. This standpoint is said to be an approach that would support a more individualised supervisee model rather than making comparisons across supervisees.

The message being put forward by Falender and Shrafanske (2007) is that a SCF could benchmark good practice and the assessing of metacompetences within practice can help both supervisor and supervisee build individual competences needed for the respective supervisee. The metacompetences aspect of supervision can therefore be a shared experience in development. However, the six challenges for psychologist/supervisors presented by Falender and Shrafanske (2007) tend to emphasise a lot of responsibility on the supervisor's part. There is nothing wrong with this in it itself, because as highlighted in the discussion, the SCF could benefit both supervisor and supervisee in their respective roles.

In the UK literature there are several references to the 'responsibilities of supervisees', which challenge the idea of supervisors having the overall position of responsibility for supervisees in relation to supervisees' practice and welfare of clients. For example, Goldstein (2008) comments on the responsibility and accountability of the supervisor on a supervisee's practice due to the context of supervision being a reflective process based on subjectivity. Milton (2008) claims, "we will never know the experience of the other as all we know is a selection of our own experience in relation to it" (p.76). Hitchings (2008) points out that clinical responsibility derives from the medical model, and this seems similar to the US position on accountability on competences developed from medical principles reported by Falender and Shafranske (2007).

In counselling psychology, psychologists are expected to be responsible as individuals, through self-awareness and reflexivity (Willig, 2001). Psychologists need to be aware of their practice both 'in-action' and 'on-action' (Strawbridge and Woolfe, 2010). Therefore, as Hitchings (2008) posits, one person cannot take responsibility for everything. To add to this, responsibilities in supervision can be influenced by systems

within the workplace (Towler, 2008), which in actual practice is another factor that creates difficulties in overall responsibility of the supervisor.

6.11 Cultural Shifts in the Supervision Relationship

To achieve accountability and shared responsibility, by both supervisor and supervisee, it seems a shift in culture is needed by supervisors from a standpoint of expert versus non-expert to one that seems more peer-oriented. This stance reflects the qualities, principles, and values of counselling psychology supervision described earlier as 'being-in-relation' (Hitchings, 2008). In this position, honesty, integrity, and vulnerability can affirm expectations and limitations in supervision, yet at the same time, keep the supervisor and supervisee grounded as humans. The individual characteristics of supervisor and supervisee will create "micro-context for one another, significantly shaping what unfolds within the proximal and distal contextual factors (e.g. social support and national healthcare policies), respectively" (Milne, 2009, p. 214).

Falender and Shafranske (2007) acknowledge the need for supervisors to have more clinical competence, meaning the supervisor should know more therapeutically than the supervisee, to support knowledge, skills, and processes for ongoing assessment. Yet, while Falender and Shafranske emphasise the seniority of the supervisor, they simultaneously propose the need for shared responsibility in the supervisor/supervisee relationship. They put forward that the supervisor and supervisee engage in ongoing collaboration, where both self-assess and self-disclose their strengths and weaknesses because this helps address expectations and limitations within supervision.

To support the peer-related position above on the supervisor/supervisee relationship, Watkins (2012) also suggests the need for dual responsibilities on accountability of both supervisor and supervisee within the supervision relationship. Watkins claims the need for reflection on shared data in the supervision process to support evidence-based and competency-based practice, but also sees the supervision process as education-driven. Watkins concludes his views, having reviewed four areas of psychotherapy-based supervision, citing: Psychoanalytical Supervision (Srnat, 2012), Cognitive Behavioural Therapy Supervision (Reiser & Milne, 2012), Humanistic-Existential Supervision (Farber,

2012), and Integrative Supervision (Scaturo, 2012). Watkins endorses a competency-based framework akin to the tenets of each psychotherapy-based model. He reports that shifts in culture and in supervision are well underway in the US, as well as in the UK, acknowledging the work of Roth and Pilling. Watkins concludes by saying there is much work to be done in this developing area of clinical supervision.

Although the importance of a collaborative relationship is well documented, Milton (2008) points out that in some supervisory relationships supervisor and supervisee may struggle with complete openness because of a danger to both egos in attending to difficulties, which is especially difficult in the workplace. As Carroll (2008) points out, in some traditions, the supervisor was seen as the 'expert' and would use a formal didactic role for teaching and learning. Falender (2014) informs us that in competency–based supervision there is a power structure where the collaborative role in supervision put forward has shown disagreement in the field of psychology in what can be viewed as a strictly hierarchal relationship, whether or not there is emphasis on the supervisor's responsibilities that includes power. Falender (2014) claims power issues can be discussed to support the collaborative relationship.

6.12 Cultural Awareness within the Supervision Process

The paper in this section looks at what helps and hinders, in cross-cultural clinical supervision and the competences that affect, as well as reflect, a safe and ethical supervision relationship (Wong, Wong, &, Ishu Ishiyama, 2013). Participants were recruited from counselling psychology departments from Canadian and US universities. Twenty-five minority graduates were interviewed independently. All were in the early stages of becoming counselling professionals. Five areas of discussion took place, as stated below:

1. Personal attributes of the supervisor;
2. Supervision competencies,;
3. Mentoring;
4. Relationship;
5. Multicultural supervision competences.

The authors investigated the most frequently reported negative themes which were grouped into five areas of personal difficulties as a visible minority.

These include:

1. Negative personal attributes of the supervisor;
2. Lack of a safe and trusting relationship;
3. Lack of multicultural awareness;
4. Supervision competencies;
5. Lack of supervision competences.

The authors open the discussion by acknowledging the importance of benchmarking cultural competences in supervision and how multi-cultural issues affect the quality of supervision. Aspects on teaching, learning, and monitoring are addressed along with the relational elements that help forge a trusting and safe environment for supervisees. A competency framework was introduced to complement the discussion and based on the person-centred approach: (Rogers, 1957) core conditions of empathy, congruence, and unconditional positive regard. A person-centred mentoring model (PCMM) is described and is one, which offers a safe and ethical approach to supervision. The authors acknowledge they are of Asian origin and highlight that in Chinese culture mentoring is widely practiced in a caring manner towards the supervisee.

The authors make distinctions between the role of mentor and supervisor and suggest the former is more relational and empathic, perhaps nurturing and developmental, whereas the supervisor's role is more educational-driven, although still with a mentoring component.

The method for data collection included interviews, which were transcribed verbatim and a coding technique was applied. Instructions on the method and procedure are clearly displayed. The authors present results in table format of the coding themes on both positive and negative responses.

A total of 150 positive incidents and 191 negative incidents were identified. For the 19 female participants, the mean numbers of positive incidents and negative incidents were 6.2 and 8.3, respectively. For the 6 male participants, the mean numbers of positive and negative incidents were 5.5 and 5.7, respectively.

Key points from this paper include:

- Participants were able to learn from, and overcome their negative experiences.
- Positive and negative themes were fairly considered.

- Positive competences, showed participants reported the need for supervisors teaching, learning, and multi-cultural competences, as well as being able to give constructive feedback and timely guidance, and moreover to support skills through role-play and providing explanations on client issues.
- Negative competences included issues such as supervisors being stereotypical, showing signs of racism, and not being cross-culturally aware.

An interesting point from the perspective of minority participants was that each found being in a minor group of counselling psychology graduates helped. Benefits were considered not only on finding placements that would show political correctness in the place of work, but also that minority participants were able to relate well to minority clients.

The authors claim that theoretically the PCMM appeared to be consistent with the needs of participants in needing a warm, safe, and nurturing model of supervision practice. This reflects supervision as a safe and ethical standpoint and that the PCMM is something to be considered for further use in supervision. As Grus (2013) describes the concept of communitarianism, a model that also appears nurturing, but in training rather than supervision, this could mean both concepts would be helpful in learning therapeutic skills because both reflect the fundamentals required by supervisees to develop their therapeutic practice. Indeed, both models incorporate better preparation for practice. If these two models incorporate the SCF model (which addresses the metacompetences put forward by Falender and Shrafanske (2007), collectively, these three models combined could provide essential skills for not only protecting clients throughout the therapeutic process, but increasing self-awareness facilitated by specific competencies described in the SCF model and in line with continued professional development, which will help orientate learners/supervisees as potential supervisors, which is clearly much needed within the transition process from supervisee to supervisor.

With regard to limitations on their study, Wong, Wong, and Ishu Ishiyama (2013) acknowledge the small sample size due to difficulties on recruitment. Another limitation put forward by the authors was only seeking views of supervisees and not supervisors which together, could have added more value to the study on what needs to take place in supervision and how this is achieved.

Nevertheless, on reflection, this study has been helpful for a few reasons. First, raising some of the important factors on cultural awareness in supervision is timely as we head towards more competence-based supervision with a growing need for more awareness on culture and diversity. Second, the study draws on views through minority graduates and their particular experiences as supervisees, yet identifying some benefits for minority graduates. In psychological research, it is important to consider any views including idiographic data, because this type of data can help shape the more obvious pictures in the context of psychological knowledge developing our understanding on cultural competences at a deeper level. Indeed, individual reports could complement the prescriptive models in finding out what actually happens in supervision, which currently, is not always the case (Milne, 2009). Third, there is a call for more awareness on multicultural and diversity issues in supervision because supervisors do not readily provide feedback on these issues and have been known to regret this later (Falender, 2014).

6.13 Ethical Issues Associated with Safe and Effective Supervision Practice

To ensure an ethical standpoint is maintained while considering the implications of supervision competences, the following statement was made: "competence is not an absolute, nor does it involve a narrow set of professional behaviours; rather competence reflects sufficiency of a broad spectrum of personal and professional abilities relative to a given requirement"(Falender & Shafranske, 2004, p. 5).

Falender (2014) has gone on to highlight many of the challenges within a supervision competency framework since earlier literature that has to a greater or lesser extent been raised throughout this review. These include:

- More training for supervisors;
- More training for supervisees;
- Value of metacompetences;
- Multicultural diversity;
- Increased self-assessment for both supervisor and supervisee;
- Ethical issues and boundaries;
- Development of international competencies.

6.14 UK Perspective

Within the UK, there is a wealth of supervision literature, but most of this is on supervision process in practice, rather than outcome in relation to the assessment of supervision competences (Roth & Pilling, 2007). The competences frameworks on practice (Roth & Pilling, 2007, 2009) and Roth, Hill, and Pilling (2009), include similar specifications on 'Knowledge' and 'Ability'. Particular to these supervision frameworks, factors include: 'General competences', 'Specific competences', Application to specific models/contexts and 'Metacompetences'. Details of all frameworks can be downloaded from www.ucl.ac.uk/CORE.

It is well documented in international and UK supervision literature that clinical supervision is recognised as a complex exchange between supervisor and supervisee. Supervisory models/theories developed provide a frame for supervision, but also because it can sometimes feel like a natural extension of therapy itself (Smith, 2009). Complexities arise due to supervision having different meanings for different people in different groups and settings. Supervision can also vary according to theoretical orientation (Roth & Pilling, 2007).

Roth and Pilling describe supervision as the following: "supervision as a formal but collaborative relationship which takes place in an organisational context, which is part of the overall training of practitioners, and which is guided by some form of contract between a supervisor and a supervisee" (Roth & Pilling, 2007, p.4).

In 2007 the Division of Counselling Psychology published 'Guidelines for Supervision, 2007. Under 'section two' on 'Competence', reference is given to:

- Awareness of professional ethics,
- Ethical decision making,
- Recognising limitations of competence,
- Recognising limitations on impairment.

These have informed the deliberations of the 'supervision training and recognition' (STAR) group and their recommendations for supervision competences incorporated in the recent BPS Generic Professional Practice Guidelines (2008) and generic policies of the BPS, Code of Ethics and Conduct (2009).

In the ‘Counselling Psychology Review’ journal, issued in 2008, a review of clinical supervision presented a special edition called ‘Occasional Papers in Supervision’, which included a number of papers introduced by Carol Shillito-Clarke and Margaret Tholstrup (2008). Authors include: Ralph Goldstein, Paul Hitchings, Michael Carroll, Miller Mair, Heather Dudley, John Towler, Pilar Gonzalez-Doupé, Nicola Gale, Katrina Alivovic, and Martin Milton respectively. Reference has already been given to authors who made particular comments on issues relating to supervision competences and the specific issues that can affect the supervisory process.

In this review various models of supervision have been briefly acknowledged, yet not given a high profile because supervision models do not correspond to the complexities of professional practice (Milne, 2009). Conversely, too much focus on models might not have helped answer the main question in this review. In relation to how supervisors practise, and through what means. Milne (2010) discusses the possibility of a ‘manual’ to support training. Further considerations are documented.

Theoretically, the foundation of supervision as viewed in this discussion relates to an emphasis on ‘experiential learning’ introduced by Kolb, cited in Milne (2009). Competence can be gained through experience of reflection and conceptualisation, thinking equals planning, and concrete experience equals feeling and doing. According to Milne (2009) supervisors are deemed competent if they facilitate all four modes of learning at regular opportunities in supervision. To account for all supervision styles, one way put forward is that supervision should be tackled within an integrative model featuring the normal cycle steps of alliance-building and goal-setting (Bordin, 1983), alongside some specific tailored supervision approaches. This is a way to address developments such as IAPT, as well as how we train and support supervisors (Milne, 2009).

Finally, to return to the beginning of this review, which asks one critical question on supervision competences (What are the main challenges attributed to clinical supervision competences?), in support of the findings above, the following considerations bring the review to a conclusion but with thoughts for the future.

6.15 The Future Position for Supervision Competences

There are many justifiable arguments on the need for supervision competences that may be for professional or political reasons. But central to this, it is important to remain focused on which way psychology moves forward with this phenomenon, ensuring that practice is ethical, and is in the best interest of our clients (Shillito-Clarke, 2010). A cultural shift is taking place on the accountability of practice and the responsibilities on individual practitioners calling for more transparency on how evidence in practice is obtained (Milne & Reiser, 2012). All authors referenced in this review acknowledge the value of supervision, particularly in training. However, as highlighted earlier by authors Falender (2014), Goldstein (2008), and Grus (2013) supervisors are insufficiently trained or appropriate training for supervisors has not been a focus of attention in the past (Milne, 2010). Lack of direction will naturally reflect on supervisors' competences to ensure supervisees become competent. Good clinicians are not necessarily good supervisors (Falender, 2014). This means, within the supervisory relationship a different dimension exists to that required of a therapist within the therapeutic relationship. For example, despite suggestions for creating a more peer-collaborative supervisory relationship, the supervisory relationship may after all, require it to be more 'expert-driven' rather than 'peer-relationship-driven'. Yet, while elements of educator exist in both therapist and supervisor roles, it seems supervision should not be viewed as an automatic extension of the therapeutic relationship.

Currently, there is no single definition on supervision competences. This is not surprising. Competence is not always something achievable, such as the competencies achievable through training. Competence is a continuum, it is developmental and contextual (Falender and Shafranske (2007). This suggests that competence may exist only within a given situation according to what premise skills have been built upon or what opportunities have been open to the supervisee. A supervisee may therefore be competent in one area of work but may not have had the opportunity to be competent in another. This does not mean they are 'competent' overall.

Before supervision competences can be standardised, globally as well as internationally. The need to conceptualise supervision would be a step in the right direction, because people need to be clear on what supervision is and its purpose (Goldstein, 2008).

Supervisees will naturally have different expectations and needs from supervision. Therefore if supervisees do not get training in supervision (Hitchings, 2008), how can they expect to know what is required of them, to become competent in assisting the process of competent practitioners? Benchmarking key factors for reflection in supervision through further investigation might be one answer.

The evidence-based movement derives from evidence-base medicine and may present good arguments for more structure in supervision (Milne & Reiser, 2012). According to Milne & Resier (2012), without this type of structure, in practice there would be too much variability, standards would slip, and maintaining quality control would be difficult. Opinions on the future of supervision competences may depend in which field you stand. For example, when working upon the evidence-base of a CBT paradigm, this infers that what has taken place is 'reality'; it is what is known. Whereas in phenomenological psychology, the philosophical base of counselling psychology rests upon assumptions of 'intersubjectivity' (Goldstein, 2008). This stance infers an openness and creativity in practice and supervision, learning from each new experience, demonstrated in the work of Carroll (2008) and Mair and Dudley (2008). At the same time, in the UK, it is important to remember that systems and the defined responsibilities for psychologists and supervisors and those who take on management tasks within those systems can all affect practice and how we think about supervision of practice. These issues are discussed by authors Gale and Alilovic (2008), Gonzalez-Doupe (2008) and Towler (2008).

6.16 Conclusion

There are undoubtedly many questions that remain unanswered on supervision competences beyond the scope of this review. Perhaps one way forward while considering supervision competences as a concept, is to apply a 'bottom-up' rather than 'top-down' process (Gibson, 1966). For example, in the resounding words of Martin Milton (2008), "What kind of supervision do I need? What focus would be useful? What supervisor will assist me with this issue? What person, structure, format do I need" (p.78). In other words, ask supervisees what they want, and despite whatever conjectures this approach might bring into the supervision arena, the rest might fall into place. At the same time, from accounts shown in this review, in the interim, we can

apply some simple procedures for monitoring competences by ensuring CPD portfolios are meaningful to the therapist's practice experiences and that they clearly demonstrate how, where and when these competences were achieved. This offers important information on developing skills for supervisors/line managers or potential employers to allow them to identify the strengths and limitations of competences. The use of job descriptions and person specifications within employment, and not just prior to, springs to mind here, to cross-reference skills on jobs, for example, at times of staff appraisal or changes in work responsibilities etc. This way, the difficulties presented in standardising competences by service providers and reflecting the unique undertaking of gaining competences by the respective trainee or practitioner and the evidence on the practice needed to achieve this goal, could become a less daunting prospect.

Finally, while we deliberate further our position on supervision competences in the UK, if we continue to share our ideas alongside colleagues across the globe, hence keep in mind new approaches from all angles, this will surely help lighten our load.

References

Bernard, J. M. (1979). Supervisor training: A discrimination model. *Counselor Education and Supervision, 19* (1), 60-68.

Bordin, E. S. (1983). A working alliance based model of supervision. *The Counseling Psychologist, 11,* 35–42.

British Psychological Society Division of Counselling Psychology (2007). Guidelines for Supervision. Leicester: British Psychological Society.

British Psychological Society (2008). *Generic professional practice guidelines*. Leicester: British Psychological Society.

British Psychological Society (2009). *Code of ethics and conduct: Guidance published by the Ethics Committee of the British Psychological Society*: Retrieved October 10, 2012, from http://www.bps.org.uk/system/files/documents/code_of_ethics_and_conduct.pdf.

Care Quality Commission (2013). Supporting information and guidance: Supporting effective clinical supervision. Retrieved April 22, 2014, from http://www.cqc.org.uk/sites/default/files/media/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf.

Carroll, M. (2007). One more time: What is supervision? *Psychotherapy in Australia, 13*(3), 34-40.

Carroll, M. (2008). Supervision, creativity and transformational learning, Counselling Psychology Review, *Occasional Papers in Supervision*, August 2008.

Falender, C. (2014). Clinical supervision in a competency-based era. *South African Journal of Psychology, 44*(1), 6–17.

Falender, C. A., Burnes, T. R., & Ellis, M. V. (2013). Multicultural clinical supervision and benchmarks: Empirical support informing practice and supervisor training. *The Counseling Psychologist, 41,* 6-25.

Falender C. A. & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington D.C: American Psychological Association.

Falender C. A. & Shafranske, E. P. (2007). Competence in competency-based supervision practice: construct and application. *Professional Psychology: Research and Practice*, *38*(3), 232–240.

Forrest, L. (2010). Linking International Psychology, Professional competence, and leadership: Counseling psychologists as learning partners. The Counseling Psychologist, *38*(1), 96-120.

Fuertes, J. N. Spokane, A., R. &, Holloway, E (2013). *Speciality Competencies in counseling psychology*. Oxford University Press.

Gale, N., & Alilovic, K. (2008). Counselling Psychology Review, *Occasional papers in supervision*, August 2008.

Gibson, J. J. (1966). The senses considered as perceptual systems. Houghton Miffin Company, Boston.

Goldstein, R. (2008). Supervision: Who needs it and for what purposes? *Counselling Psychology Review, Occasional Papers in Supervision*, August 2008.

Gonzalez-Doupé, P. (2008). Group supervision in crisis management organisations, *Counselling Psychology Review, Occasional Papers in Supervision*, August 2008.

Grus, C,. L. (2013). The supervision competency: Advancing competency-based education and training in professional psychology. *The Counseling Psychologist, 41*(1), 131-139

Hawkins, P., & Shohet, R. (2007). *Supervision in the helping professions*. McGraw Hill. Open University Press.

Hitchings, P. (2008). Counselling psychology and supervision. *Counselling Psychology Review Occasional Papers*, August 2008.

Holloway, E. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage Publications, Ltd.

Lane, D.A., & Corrie, S. (2006). *The modern scientist-practitioner: A guide to practice in psychology*. London and New York: Routledge, Taylor & Francis Group.

Mair, M., & Dudley, H. (2008). Seeing in the dark or writing as lighting, *Counselling Psychology Review, Occasional Papers in Supervision*, August 2008.

Milne, D. L. (2009). *Evidence-based clinical supervision: Principles and practice.* Malden, MA: BPS/Blackwell.

Milne, D. L. (2010). Can we enhance the training of clinical supervisors? A national pilot study of an evidence-based approach. *Clinical Psychology and Psychotherapy, 17*, 321-328.

Milne, D. L., & Reiser, R. P. (2012). A rationale for evidence-based clinical supervision. *Journal of Contemporary Psychotherapy, 42*(3), 139–149.

Milton, M. (2008). Expectations of Supervision: Everything to everyone? … or nothing to no-one? *Counselling Psychology Review, Occasional Papers in Supervision*, August 2008.

Owen-Pugh, V., & Symons, C. (2013). Roth and Pilling's Competence framework for clinical supervision: How Generalisable is it? *Counselling and Psychotherapy Research, 13*(2), 126-135.

Prasko J., Vyskocilova J., Slepecky M., Novotny M. (2011). Principles of supervision in cognitive behavioural therapy. *Biomed Pup Med Fac Univ Palacky Olomouc,* Czech Republic, *156*(1), 70-79.

Reiser, R. P., & Milne, D. (2012).). Supervising cognitive-behavioral psychotherapy: Pressing needs, impressing possibilities. *Journal of Contemporary Psychotherapy, 42*(3), 161-171.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality changes. *Journals of Consulting and Clinical Psychology, 21*(2), 95-103.

Roth, A. D. & Pilling, S. (2007). *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders.* London: Department of Health.

Roth, A. D., & Pilling, S. (2008). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy, 36*(2), 129-147.

Roth, A. D., & Pilling, S. (2009). *A competence framework for the supervision of psychological therapies*. Retrieved April 20, 2014, from http://www.ucl.ac.uk/clinicalpsychology/CORE/competence_frameworks.htm

Roth, A. D., Hill, A., & Pilling, S. (2009). *The competences required to deliver effective Humanistic Psychological Therapies.* Retrieved April 23, 2014, from http://www.ucl.ac.uk/clinical-psychology/CORE/humanistic_framework.htm

Shillito-Clarke, C. (2010). Ethical issues in counselling psychology. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp. 507-528). London: Sage Publications, Ltd.

Shillito-Clarke, C. & Tholstrup, M. (2008). Introduction. *Counselling Psychology Review, Occasional Papers in Supervision*, August 2008.

Stoltenberg, C. D. (1997). The integrated developmental model of supervision, *Psychotherapy in Private Practice, 16*(2), 59-69.

Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco: Jossey-Bass.

Smith, K. L. (2009). A brief summary of supervision models. Retrieved April 16, 2014, from https://www.gallaudet.edu/Documents/Academic/COU_SupervisionModels[1].pdf

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of counselling psychology* (pp. 3-22). London: Sage Publications, Ltd.

Towler, J. (2008). 'The influence of the Invisible client': A crucial perspective for understanding counselling supervision in organisational contexts, *Counselling Psychology Review, Occasional Papers in Supervision*, August 2008.

Watkins, C. E. (2012). Psychotherapy Supervision in the new millennium: Competency-based, evidence-based, particularized, and energized. *Journal of Contemporary Psychotherapy, 42*, 193–203.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Berkshire: The Open University Press.

Wong, L.C.J., Paul T. P. Wong, P.T.P., &, Ishu Ishiyama, F. (2013). What helps and what hinders in cross-cultural clinical supervision: A Critical Incident Study. *The Counseling Psychologist, 41*(1), 66-85.

Woolfe, R., & Tholstrup, M. (2010). Supervision. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp. 590-608). London: Sage Publications, Ltd.